SEPTEMBER 1956

Mental Hospitals

A PSYCHIATRIC TEAM IN ACTION

BUSINESS AND FINANCE MANAGEMENT

SELECTIVE MENUS AND PREPORTIONED MEATS

BUILDING STUDY REVEALS SIGNIFICANT TRENDS

American Psychiatric Association

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THIS MONTH'S COVER

EXCEPT FOR DISASTER by fire or enemy action, the main threat to the Provincial Mental Hospital at Essondale, British Columbia, is the seasonal threat of flooding. This occurs on an area of the hospital property known as Colony Farm, which is adjacent to the Fraser River and is protected by dykes. Some 300 patients live at Colony Farm, which has valuable farm land and cattle.

About eight years ago, following severe flooding in the Lower Fraser Valley during which it was necessary to evacuate 200 Colony Farm patients to other parts of the hospital, a Disaster Organization was set up to mobilize manpower and materials in case of future emergencies.

Two years ago this organization was expanded to fit into the Civil Defense organization of the Vancouver Target Area, which encompasses the hospital. In April 1956 the hospital was officially designated a municipality within the Target Area in order to organize its resources in preparation for any severe disaster and also to become eligible for Civil Defense financial aid.

Although we have not yet held any simulated Civil Defense exercises at the hospital, I, as Civil Defense Coordinator for the institution, keep in frequent contact with the Vancouver Target Area Coordinator and meet periodically with other Coordinators.

The key members of our hospital Civil Defense organization have taken advanced training either at the National Civil Defense Training School near Ottawa or at the Provincial training headquarters in Vancouver. In addition, 100 staff members from various departments, particularly nursing personnel, have voluntarily completed courses in basic Civil Defense given by our own instructors. All nursing staff are trained in First Aid, but so far few non-medical employees have this training.

The hospital's Disaster Control Headquarters is located in the fire hall, which is constantly manned and equipped for any emergency. In addition a large room is being equipped as a Civil Defense Training Center and storage area for emergency equipment. Certain other readily accessible areas are used for stockpiling such items as sandbags and tools. A portable lighting plant is kept at the fire hall and a boat is available at the Colony Farm. Emergency medical supplies and food are always available from the pharmacy and stores departments.

We have an agreement of mutual aid with the surrounding communities involving not only special equipment but manpower. Also, if community hospital facilities were taxed during a disaster, our institution would help provide food, shelter and clothing. We already have had several occasions to test our preparedness. In the 1948 flooding of Colony Farm, for instance, local citizens volunteered, along with patients and employees, to assist in reinforcing the dykes, and we had to set up emergency measures to feed and clothe these helpers. Last year a serious fire which destroyed our large Industrial Therapy building (see MENTAL HOSPITALS, Sept. 1955) and threatened nearby patient dormitories was controlled through the efficient action of the hospital Disaster Organization, with prompt aid from local fire departments.

A. M. GEE, M.D., Director
Provincial Mental Health Services

Note: Copies of Essondale's Civil Defense Organizational Chart are available from M.H.S. on receipt of 3¢ stamped return envelope. See p. 22 for disaster plan recommendation of the A.P.A. Central Inspection Board and for news of Civil Defense maneuvers at other hospitals.

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No. 9 in a Series on Mental Hospital Administration

A PSYCHIATRIC TEAM IN ACTION

The organization, staffing, management and control of professional services for medical care

By WALTER E. BARTON, M.D., Superintendent
Boston State Hospital, Massachusetts

IN ITS EARLY YEARS, around 1840, close coordination between all staff members of the Boston State Hospital was not very difficult. The principal reason was the small size of the institution.

Dr. John S. Butler, the first Superintendent, had only one hundred patients. His family lived their lives in close contact with the patients, as did the other employees.

Mrs. Butler did her sewing in the ward day-hall. The Butler children romped and played there. Patients joined in the work and helped with the chores, visited and exchanged pleasantries with the family. It was a closely knit group—an extension of the family.

The effects of this closeness, of the interest, the kindness, and the use of simple daily activities to keep minds busy, was known as "moral treatment".

When the United States began to grow so rapidly after the Civil War, a great mass of patients poured in upon the state hospitals. There were not enough doctors, too few attendants. Personal contact was lost in the regimented mass.

Recently, attention has once again been focused on the importance of close personalized attention to the individual patient.

Today our large public mental hospitals are very complex organizations. The patient comes in contact with many people who have specialized tasks to perform. Upon admission, he is physically examined by a doctor. His blood and urine are examined by laboratory technicians; his X-rays are taken by technicians and read by radiologists; his brain waves may be studied by an electroencephalographer. On the ward he receives care from a psychiatric nurse and from aides. The psychiatrist will carefully study his emotional and psychiatric status, and will secure his history from relatives. A medical record librarian will prepare the clinical case record. A clinical psychologist will make an objective assessment of the patient by means of selected tests. The social worker will work with him and with his family to solve social problems, change attitudes toward the patient, and interpret treatment.

Next, a treatment plan will be prepared and individual or group therapy prescribed. Electric shock, insulin coma or chemotherapy may be used. Perhaps physical therapy will be indicated. The occupational therapist will plan an activity program for the patient, assisted by industrial therapists, corrective therapists, manual arts therapists, recreational therapists, music therapists and educational therapists.

Each of these treatments is the responsibility of a trained person, who oftentimes has a special interest only in his own form of therapy.

The list of persons concerned in the total treatment plan is by no means exhausted by the above. There are still those individuals responsible for entertainment, convalescent care, vocational guidance and placement, vocational training and supervision, and those who operate the psychiatric outpatient department.

The Psychiatric Team

It has been fashionable to talk about the Psychiatric Team. We like to think that we are a group of smoothly coordinating, cooperating specialists, working toward a common objective. More often the Psychiatric Team has been composed of individuals, each working in his own area, in isolation, out of contact with those about him. Each one has been making a worthwhile contribution; but oftentimes, there has been little integration.

There is even some question as to who is on the Psychiatric Team. The doctor, the social worker and the clinical psychologist are considered members. This concept is well established in connection with clinic practice. The psychiatric nurse has discovered that she is not considered as being on the Psychiatric Team. Yet in psychiatric hospitals, the doctor or the social worker may see the patient even less than one hour per day, while the nurse spends eight hours a day, or longer, with the patient. Others who contribute to the diagnostic study and the treatment plan also have a claim to membership on the Team.

Problems of Organization, Staffing and Management: What is a practical organization plan that will make it possible for a diversified group of specialists to work together in the patients' interest? Most important of all is a competent leader with the responsibility and the authority to do his job. Next is an efficient organizational structure through which he is able to delegate responsibility.

A suggested organizational plan has five or six major hospital divisions. These are directed by carefully selected leaders who constitute the top echelon or cabinet and report directly to the Superintendent.

The major Organizational Divisions suggested for a large mental hospital are:

1. Clinical Medicine—headed by the Clinical Director with medical policy set by a Medical Executive Committee, with an elected and rotating representation of the Resident and Visiting Staff.

2. Professional Care—headed by the Assistant Superintendent to provide medical direction to hospital departments with a treatment function and also to complicated problems of supply and administration (such as Medical Records, Occupational Therapy, Laboratory, X-Ray, Pharmacy, etc.).

3. Nursing—headed by the Director of Nursing and including ward services and nursing education.

4. Business Administration—headed by an Assistant Superintendent in charge of business who is a qualified layman, exercising supervision over departments including laundry, engineering, building maintenance, nutrition, transportation, etc.

5. Research—headed by a Director of Research and assisted by an advisory panel of qualified consultants with research skills.

6. Treasury—headed by the Treasurer and charged with responsibility for payrolls, patient accounts, and accounting. Some organizations will prefer to place this function under the Business Division.

Each division head exercises direct supervision over the departments in the division. Again, the number of departments should be about six so that close contact may be maintained between division head and the department head. For example, in the Medical Department of the Clinical Medicine Division, the hospital departments suggested are: Admission; Medical; Geriatric; Men's Continued Treatment; Women's Continued Treatment; Outpatient and After-Care.

The ward physician exercises supervision over the ward team and reports to the head of the Admission Department, who holds conferences with his staff of ward physicians.

Staffing: The American Psychiatric Association staffing recommendations are minimal guides to meeting mental hospital personnel needs. This has been amply demonstrated both from experience and the time study approach. The best possible leaders should be selected for divisions, departments and sections, and they should have delegated to them the responsibility and the authority they need to do their job. The principle of developing an island of good medical practice, with whatever personnel is available, is recommended as a sound approach when there are too many patients and not enough staff.

Management: The three principal aspects of management are Education, Communication and Integration. How these are employed will be discussed after illustrating a typical problem that results from fragmentation of patient therapy and management.

The psychiatric nurse will be used as the example to show how each individual specialist has a contribution to make and how he must relate it to all others concerned in fulfilling the needs of patients.

The different kinds of nurses illustrate specialization within a specialty. There are *administrative nurses,* such as the Director of Nursing, the Educational Director, the Nursing Faculty and the Supervisors. *Special treatment nurses* work in the admission room, give electric shock or insulin coma treatments, have the responsibility for running treatment rooms and giving medications or comprise the Operating Room Team. *Research nurses* are skilled observers of patient reaction and participate in investigative studies. *Therapeutic nurses* work directly with patients.

The Approach of the Nurse Therapist to Her Problem

One of the major responsibilities of the nurse working directly with patients is the preparation of patients for therapy. If group therapy is ordered by the physician, the nurse must first decide whether she is going to coax the patient to attend, try to persuade him by using "salesmanship", or whether she is to use actual force to get him there.

Who Makes the Decision? The nurse, usually. If the patient in group therapy becomes restless and anxious and asks the leader if he may go to the bathroom, the doctor usually gives permission without further thought. But it is the nurse's responsibility if the patient, in a disturbed state, with anxieties freshly aroused by the group therapy, goes into the bathroom and proceeds to try to hang himself. Does the doctor ever stop to think how the reluctant patient, for whom shock therapy has been ordered, actually gets to his treatment each time it is given? Again the nurse must make the decision as to persuasion, force and the technique to be used to get him there. When the doctor says "Take Catherine for a walk", it is a simple order that expresses a wish for an individual patient. It is the nurse who must deal with the problem of jealousies of other patients on the ward because of the individual attention demonstrated by the doctor and by the nurse to a single individual. The nurse must deal with the anxieties, the fears, the discouragements and the questions that patients have about the treatments.

How Much Guidance Does the Nurse get from the Physician in Making Interpretations? The nurse, too, must deal with the patients' frustrations and hostilities. A disturbed and excited patient may suddenly break six panes of window glass. When the nurse attempts to stop him, he may jump at her and tear her uniform. The nurse may then call the doctor and tell him that the patient has a laceration requiring suturing. The doctor tells the nurse to bring the patient to the treatment room. Does the doctor ever stop to think how the disturbed and excited patient, who has already attacked the nurse, is to be brought by her to see him?

Another duty of the ward nurse is to observe the daily behavior of the patient and to keep records that will be helpful to the psychiatrist. She may report unusual occurrences, eccentric or odd behavior and emotional outbursts. A not uncommon situation is illustrated by the

following: A mischievous patient blocks up holes wherever he can find them. He wads up paper and stuffs it into keyholes, plugs key-operated light switches and floor drains, and stuffs his pants in the toilet. The maintenance foreman, harassed by plumbing stoppages and electric repairs, complains to the Steward; the Steward tells the Superintendent; the Superintendent informs the Director of Nurses. The Director of Nurses tells the Nursing Supervisor, and the supervisor instructs the Ward Nurse to control her patients better. The nurse tells the doctor her problems with the patient. What happens? The patient gets transferred to another ward. When does therapy begin? Who tries to understand the meaning of the patient's behavior? Who tries to help the nurse understand the behavior and deal with it effectively? It is a real problem to her, and one that must be solved.

The Nurse gets Caught in the Game of Buck-Passing: Let us suppose five men went out from the ward on liberty and returned drunk. The ward nurse might bawl them out. She also might issue an order to the effect that if they do not keep regulations, as set down, they will be denied privileges. Perhaps the nurse on the ward received a complaint from the police, channeled through the Administrative Nursing Office. Perhaps the nurse intended to discuss this with the doctor when he makes ward rounds. However, the doctor's appearance on the ward is often unpredictable, for his schedule is frequently very complex. Suppose he makes his rounds when the nurse in charge of therapy is at Head Nurses' Meeting. He learns from one of the patients that privileges have been denied patients by the nurse. He may be indignant, and because the aide on duty is the only one available, the aide may catch the brunt of the indignation for making decisions. The doctor points out that it is the responsibility of the patient-government to discipline the patients. The nurse is caught in the middle, with the responsibility for maintaining discipline and the dissipation of her authority to others with whom she cannot even discuss the problem jointly. As a result, the next time, the nurse may make no report of aberrant patient behavior, if her actions are not tolerantly received. Stanton and Schwartz have found that much of the actual disturbance of patients on the ward is the result of such conflicts between the personnel. The more opportunity there is for a nurse to talk with the doctor, the more opportunity there is for him to receive her comments directly and not through subordinates; the more specific are the orders, the less chance there will be of being caught in the game of buck-passing.

What To Do About All This

Education for Mutual Understanding: All of the hospital personnel actively concerned in patient care and treatment need basic preparation in order to understand patient problems. This is particularly true of members of the Psychiatric Team who have a professional responsibility for therapy. The basic preparation must include a knowledge of the dynamics of human behavior and a knowledge of dynamic psychiatry. There must be understanding of the goals in therapy and an understanding of the specific techniques that will be employed in therapy.

An active in-service educational program should be a part of the teaching program of every hospital. Such programs should be available for nurses, social workers, occupational therapists, industrial therapists, aides and others. This education may consist of informal conferences or may be more structured. The educational program should deal directly with the kinds of problems about which the particular group is troubled, and with the solutions to those problems.

There must also be opportunity for shared learning experiences between different professional groups. In the Boston State Hospital we have three solutions to this problem. The first is a weekly seminar. This is open to all employees and is well attended. Visiting lecturers, each of whom is an authority in his own field, talk about some aspect of psychiatry or its related fields, and this is followed by general discussion. A second device is a weekly case conference designed particularly for its teaching value. Care is taken to invite all to contribute, and a single case is dealt with thoroughly. We feel this teaching device to be far better than four or five cases handled in one morning in a superficial fashion.

Instead of having a daily staff meeting for diagnosis and treatment, a "ward round technique" is used—the senior psychiatrist and his assistants have the authority to make decisions themselves. If there are special problems, the senior psychiatrist may call upon more experienced hospital leaders as consultants. Thirdly, we have developed within our training program a course for residents in administrative psychiatry. The nurse, social worker, psychologist, occupational therapist, etc., bring a case before the residents that illustrates an administrative problem, such as the patient who escapes, the excited patient, the depressed patient, the use of Rorschach tests, etc. In this way, the young doctor in training learns early to listen to the skilled aide or the industrial therapist. The discussion brings out the cooperation necessary between members of the staff to achieve a common objective.

Communication: All therapists, whether they are handling individual cases in psychotherapy or groups, should have a regularly scheduled meeting which representatives of all disciplines attend and in which they participate. In this way, the common problems of group leaders can be discussed and understood. Resolution of anxiety for the leader is easy in the supportive setting of a group with common problems. The presentation by an experienced therapist of his errors and mistakes may give some of the younger therapists enough confidence to talk freely about their own shortcomings. An attempt should be made to create a helpful atmosphere in which all forms of therapeutic problems can be freely discussed.

Any member of the Psychiatric Team may carry individual patients in psychotherapy or some form of intensive therapy. The number carried in this fashion will be limited to the capacity of skilled supervisory personnel. The immediate supervisor of the social worker doing intensive case work may be the head social worker. The immediate supervisor of a- head nurse doing intensive therapy may be one of the nursing faculty. The supervisor of the young resident should be an experienced psychiatrist. In any instance, the psychiatrist

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who is chief of the service on which the patient resides should be accessible for guidance and comment.

It has been found useful for the free communication between disciplines to utilize special devices like role-playing with reversal of roles; for example, assume that a patient has thrown a glass of water in the nurse's face. What does the nurse say to the patient? What does the doctor say when he comes onto the ward? The roles may be reversed so that the nurse becomes the patient, a social worker the nurse, a psychologist the doctor, etc. Because individuals are very apt to say what they think under such a situation of stress, the discussion can be lively and directed easily at the heart of team relationships.

Everyone on the Psychiatric Team must accept responsibility for the transmittal of information. Unless the social worker tells the nurse and the doctor that relatives are to call for a patient, confusion will result. Similarly, the doctor must inform the nurse and the social worker when he deals directly with relatives concerning the release of the patient. This is also true when other personnel, such as activity therapists, or occupational therapists are involved. Sometimes briefly written inter-office memoranda are sufficient. Sometimes progress notes in the case record, to which others' attention may be called, will serve the purpose. Of course, face-to-face interview might be the most desirable way to transmit general information, but it is not always possible.

One of the most useful forms of communication is a complete clinical case record. Many clinical medical records are so perfunctory that they are not very useful. Often records of treatment and results of therapy are not filed in the case record. Therapeutic summaries and memoranda of significant happenings, when posted in the case record, are very useful. Professional staffs should have access to the case records. Records will be used if they are available in the Service Chief's office or in a record room near where the patient lives. Central record rooms may be more efficient, but they are not very useful.

Integration: Coordination and integration of the activities of the professional team are greatly facilitated if there is an effective master schedule. Such an overall master schedule establishes certain times for major activities on the ward, and specifies the time required for basic care. For example, while the master schedule is the same on all wards in certain items, it is unique in others for each ward. The time for breakfast, dinner and supper will be indicated. So will bathing days, barber shop and beauty parlor visits, church, visiting hours, and so forth.

Treatment such as electric shock, insulin coma, group therapy and individual therapy should be noted. There will be a specified time for ward rounds, and the doctor will be available at certain times for sick call. Within this framework of prescribed activities, there will also be scheduled occupational therapy and recreational therapy.

To avoid conflict, entertainment should be scheduled in the late afternoon or in the evening hours and on Saturdays. Recreational therapists may sometimes be assigned with profit on a shift from 1:00 to 9:00 P.M. Volunteers, including units of the American Red Cross, will make it possible to fill evening and weekend entertainment hours.

The Boston State Hospital finds it useful in its master schedule to adopt the general rule that all physicians and personnel work with patients in the morning. All teaching activities are in the afternoon. All individual therapy and group therapy hours are scheduled in the afternoon. A time is set aside for group conferences and in-service education attended by all. Telephone calls from relatives are accepted only between 8:30 and 9:00 A.M. and 4:30 and 5:00 P.M., unless the patient is on the danger list. Such a master schedule permits the physician to plan his time with a minimum of interruptions. The same is true for other team members.

Another useful device of great importance in integrating team members' activities is the Ward Service Conferences. All team members concerned with management and therapy of patients on a ward, building, or a unit of buildings, meet for a full hour a week to discuss mutual problems. The psychiatrist has the obligation to draw out comments from staff associates, encouraging full expression. Participants must know that they may freely express their opinions in this conference without any hazard of retaliation or personal hurt for expressing themselves. Only if there is free expression by all participants will the maximum integrating effect be obtained. A properly conducted Ward Service Conference is the most useful device in promoting integration.

Policy-making is another occasion when cooperative enterprise may achieve integration. It is suggested that department heads and middle management or supervisors' groups be held weekly.

The administrator has the responsibility for the development of willing, harmonious working relationships. It is his job to see that oil is applied to the squeaking wheel. He must energize the laggard. The common purposes and goals must be clearly defined and held before the group. He must let people work out the solutions to their own problems whenever possible. There is opportunity for cooperation, and working compromises are encouraged. Whenever a policy is to be made, the persons who must put the policy into action should be given an opportunity to express themselves as to how the policy should be stated. Their ideas may be corrected by others in authority and then circulated in rough draft for critical comments. Revisions will be made, and the final policy then crystallized for inclusion in the policy or procedure book. A policy developed by this method has a more ready acceptance and a better chance to be put into practice, because the persons immediately concerned have had a part in shaping it.

Responsibility: There are many different administrative patterns. The two principal ones might be symbolized by the "ladder" concept of authority or the "circle" concept of authority and responsibility. While channels of authority represented as steps on the ladder may be necessary, in actual practice the doctor can be just as much of a leader sitting in a group as he is in his office. The team can be captained from a huddle as well as from a straight chair. The doctor may still be the central figure sitting in the group, tolerant to the demands of others and to the interactions about him, and yet

available for the negative reactions. There must be a readiness on the part of each team member to learn from others. The psychiatric aide or the institutional porter should have a voice if he cares for the patient.

Leaders must learn to delegate responsibility, for when one has responsibility, there is greater interest in the task at hand. It is axiomatic that when responsibility has been given, undercutting of authority and overruling must be avoided. The subordinate must be given support and encouraged to make his own solutions. The leader must be consistent in his demands.

The central core of responsibility must always be the patient's needs. Is patient-centered care the dominant concern of all? How can the individual employee help the individual patient? Is everything being done by each employee for the patients in his charge? Does each worker have a clear understanding of his responsibilities and of his role? Is understanding service the goal of each department?

There is a shining example in the devotion manifested by loyal employees toward human beings in distress. We know of no better example of this than the alert ward physician who comes to see his patient during an acute panic reaction or after some administrative incident such as the patient's setting fire to his room. When other members of the Psychiatric Team see the doctor respond, they will tend to exert themselves in similiar situations. Psychiatric emergencies are as real and as demanding as medical emergencies. Each member of the Psychiatric Team has a job to do and should try to do it well. But something more than just doing one's job well differentiates those worthy of the title "Team Member". The devotion to purposes beyond the consideration of five 8-hour days or a forty-hour work week is necessary. It means more than just earning a salary or a fee. The Psychiatric Team member who is worthy of the title "professional worker", will demonstrate an interest in the task at hand, show his sincerity of purpose and display an enthusiasm that goes beyond the call of duty.

Book Reviews

CENTENNIAL PAPERS, ST. ELIZABETHS HOSPITAL, 1855-1955. **Centennial Commission, St. Elizabeths Hospital, Washington, D. C.; Waverley Press, 251 pages, 1956. $3.50**

This is a book of wide appeal. Every member of a professional psychiatric team, working in an institutional setting will find something of interest about a most famous mental hospital. The historical sketch by Dr. Winfred Overholser is most enjoyable. Nolan D. C. Lewis reviews the scientific contributions of the St. Elizabeths Hospital Staff in the 100 year period. There are also reports of psychiatric work in Spain, France, Germany, England and South America, as well as articles on occupational therapy, psychiatric nursing and social work.

This reviewer found most interesting Henry Brosin's chapter on "Challenges in Residency Education", Gardner Murphy's chapter on "Needed Research into Personality Structure", and MacDonald Critchley's chapter on the "Nature and Content of Aphasic Utterance."

St. Elizabeths Hospital received its first patient on January 15, 1855 in a new building for 90 patients erected at a cost of $100,000. Dorothea Dix penned the act that founded the Federal hospital for the care of the mentally ill. She wrote the introductory sentence to the act, which reads, "The title of the institution shall be the Government Hospital for the Insane and its object shall be the most humane care and enlightened, curative treatment for the insane of the Army and Navy of the United States and of the District of Columbia." These have been the hospital's guiding principles ever since that time.

Treatment at the start of the nineteenth century consisted of bleeding, purging, emetics; these were replaced in the new hospital with moral treatment, pleasant surroundings, kindness, personal attention and entertainment. An effort was made to engage all patients in occupation and to develop good interpersonal relations between staff and patients. Less than seven years later, the hospital had 250 beds added for the Army's use during the Civil War. This new Army section was called St. Elizabeths. It became the popular name for the whole hospital. The Superintendent at that time expressed surprise that war brought no increase in mental illness requiring hospital treatment. He reasoned that the objective character of the stress was probably responsible for this fact as against the tension arising from self-indulgences in peace time.

There are many firsts in the distinguished career of St. Elizabeths. In 1897, the section for the criminally insane; in 1894, the three-year school of nursing; in 1913, William A. White's championing of psychoanalysis and of emphasis on psychotherapy and individual attention; establishment of a Psychological Laboratory, and the Pathological Laboratory; and in 1920, a Department of Medicine and Surgery; in 1922, the first use in this part of the world of malarial therapy in general paresis; the early application of occupational therapy and social work that ultimately made the hospital internationally known.

Dr. Brosin's interesting article on "Challenges in Residency Education" calls attention to the need for residents who are better educated men, with a primary interest in ideas rather than in educational courses or in learning techniques; men who have had time to mature and time for informal conversation; men who have had time for research. The need is to train men for the practice of psychiatry in 1980. Gardner Murphy calls attention to some much needed research into the physical, chemical, biological, social, cultural, and psychodynamic factors in mental illness. Critchley, in discussing what aphasics talk about, points out their poverty of speech, particularly in the area of communication rather than in emotive and expressive use of language.

WALTER E. BARTON, M.D.
Boston, Mass.

THE NURSE AND THE MENTAL PATIENT. **Morris S. Schwartz, Ph.D. and Emmy Lanning Shockley, R.N. Russell Sage Foundation, New York, 1956, 284 pp., $3.50**

This book grew out of the same research project that resulted in the publication of "The Mental Hospital" by Stanton and Schwartz. In the latter book, the relationship of the organization and administration of the mental hospital to patient care and improvement was studied and documented. This book limits itself to study and analysis of the interpersonal relationships of nursing personnel and patients, and the relationship of the nurse (or aide) to her colleagues as they affect the patient.

The book is written in two parts. The first part deals with recurring problem situations such as fear and patient assaultiveness, the patient is withdrawn, the patient has eating difficulties, the patient is hallucinated, the patient is suicidal. The heart of each chapter is one or more illustrative verbatim accounts of nurse-patient contacts and/or a discussion of these contacts in conference with the sociologist or other nursing staff. The verbatim material is then elaborated by the authors to show the elements in the relationships of nurse to patient, the steps in understanding the meaning of specific situations and the ways in which a nurse can deal with them to the best interests of patient care and her own growth of knowledge, maturity and job satisfaction. There is constant examination in each situation of the role of the nurse, her feelings and her behavior and their effect on patient behavior. The case material permits such presentation beautifully.

In a brief summary statement of this section, the authors say:

"When a patient develops a pattern of difficulty such as incontinence, assaultiveness, withdrawal, and so on, the nurse is confronted with a problem situation which she tries to solve The interpersonal relations she carries on in general with the patient and those she maintains specifically with reference to his pattern of difficulty can either help to sustain and reinforce the patient's behavior or contribute to changing and eliminating it.

"In a problem situation, the patient relates to the nurse with his pattern of difficulty and the nurse responds to it. The patient, in turn, responds to her response, and this, again, elicits another reaction from the nurse. Thus, there is continuing interaction —action and reaction, response and counterresponse—between the patient and the nurse. Through this interaction each contributes to making the relationship what it is and what it will become. In this chain of interaction the nurse affects the patient in many ways, and the patient also influences the nurse. Because of the reciprocal influences the patient and nurse have on each other, they can modify or reinforce each other's behavior in significant ways. The nurse's therapeutic task is to observe and to develop a clearer awareness of the subtleties in her relations with the patient. With this awareness she can try to change her responses to the patient so that the patient will be able to change his responses to her; she can try to maintain their relations with each other in such a way that the patient will no longer find it necessary to continue his pattern of difficulty. This does not mean that the nurse forces the patient to change but that the change in his behavior emerges from their relationship; that is to say, the patient changes because of the way he and the nurse are participating together."

The second and shorter part of the book gives a more or less didactic exposition of the interpersonal problems that confront the nurse (or aide) in problem situations. "In order to deal effectively with each type of situation, the nurse tries to understand the patient and tries to communicate with and relate to him in a way that will be mutually satisfying."

This book can be read with profit by anyone who has personal contacts with psychiatric patients. It is written simply enough so that aides and other personnel with limited formal training can understand it.

"The Nurse and the Mental Patient" will be especially useful to the nurse educator, particularly in using discussion types of teaching methods.

LUCY D. OZARIN, M.D.
Washington, D. C.

People & Places

Dr. Robert Gatski was named Superintendent of the Danville (Pa.) State Hospital . . . **Boston Psychopathic Hospital** has been re-named the Massachusetts Mental Health Center . . . **Dr. Karl Bowman** retired on July 1 as Medical Superintendent of the Langley Porter Clinic, San Francisco, Calif. . . . **Dr. Harry C. Storrs** retired June 30 as Senior Director of Letchworth Village, Thiells, N. Y. . . . **Dr. James O. Cromwell** became Superintendent of the Independence (Iowa) Mental Health Institute; he previously served as Superintendent of State Hospital South, Blackfoot, Idaho . . . **Dr. P. L. Hays** was appointed Superintendent of Eastern State Hospital, Vinita, Okla. . . . **Dr. Ewing H. Crawfis,** formerly Superintendent of the Arkansas State Hospital, was named Superintendent of the Cleveland Regional Treatment Center in Ohio . . . New York's Commissioner of Mental Hygiene, **Dr. Paul H. Hoch,** was named "Man of the Year" by Rho Pi Phi, international pharmaceutical fraternity. The award cited Dr. Hoch for his "outstanding leadership in the research and treatment of mental illness, and his dedication to the welfare of its victims." . . . **Dr. Robert A. Haines** has assumed superintendency of the Longview State Hospital in Cincinnati, Ohio . . . **Dr. Roy D. Edwards** resigned in July as Superintendent of Western State Hospital, Hopkinsville, Ky., to enter private practice . . . Oklahoma has appointed what is believed to be the first woman superintendent of a state mental hospital: **Dr. Rheba Edwards** became Superintendent of Western State Hospital, Fort Supply. She succeeds **Dr. Frank Adelman,** who has entered private practice . . . **Dr. T. Glyne Williams,** formerly Clinical Director at Spring Grove State Hospital, Md., is to direct the Yale University Pilot Study in Administrative Psychiatry, starting September 1 . . . **Dr. Guy H. Williams** retired July 1 as Superintendent of Hawthornden State Hospital, Macedonia, Ohio. He had been in the State's service for 53 years . . . **Dorothy M. Richardson,** Statistician for the A.P.A. Central Inspection Board, has been named official statistician for all projects undertaken by the A.P.A.

Behavior Profile Gives Patient-Information at a Glance

By W. EARL BIDDLE, M.D., Clinical Director, Men's Division
and EMANUEL CHAT, M.D., Clinical Director, Women's Division
Philadelphia (Penna.) State Hospital

PERSONS IN administrative hospital positions who are responsible for a large number of patients often need quick access to information about their behavior. The Philadelphia State Hospital Behavior Profile was designed to fill this need. The Profile gives much information in concise form. (See figure 1.) On only one line the Philadelphia Profile indicates: (1) physical status, (2) habits of work, (3) medication or treatment given, (4) sex behavior, (5) attention to appearance, (6) destruction, (7) eating habits, (8) specific problem behavior, (9) physical activity, (10) habits of excretion, (11) cooperation with fellow patients and visitors, and (12) cooperation with hospital personnel. These twelve categories include most of the behavior characteristics about which inquiries are most frequently made of the personnel in charge of the patients.

PHILADELPHIA is the key word which serves as a mnemonic for the twelve categories of behavior. (See figure 2.) In each category five gradations are arbitrarily set up. In general these gradations vary from that which is most desirable to that which is least desirable. Note that the initial letters of the first word in each of the categories spell out the word PHILADELPHIA. The number which precedes the most fitting description of the patient's behavior is placed in the appropriate column which is headed by the initial letter on the Profile Sheet.

Evaluation of behavior is done best by group personnel discussion because one employee will be familiar with some aspects of behavior which are unknown to another. Some of the categories will need two or three numbers for an accurate description. If a patient is addicted to alcohol, an eloper, and is suicidal, for example, the numbers 2, 3a and 5 will appear in the second "L" column. Some questions will arise concerning the proper category under which a certain behavior characteristic should be placed. Most of these problems can be taken care of by placing them under what appears to be the most appropriate column and adding an explanatory word or phrase in the "Comment" column. If the behavior characteristic does not seem to fit in any other category it should be entered as number 4 under the second "L" column ("other problem behavior"), with an explanation under "Comments".

The Philadelphia Profile is intended to provide an objective evaluation of behavior. It does not give information about the mental condition of the patient other than that which is disclosed by his behavior. The variability of psychiatric impressions and opinions makes it very difficult to obtain an objective evaluation even by the most expert psychiatrists. The Philadelphia Profile is designed so that it may be constructed by nurses and attendants who need not be expert in the field of psychiatric theory. The information obtained from the

Figure 1

PHILADELPHIA STATE HOSPITAL BEHAVIOR PROFILE

Building or Unit:
Date: Evaluated by:

Name	Case Number	Age	P	H	I	L	A	D	E	L	P	H	I	A	Comments
John Doe	23456	41	1	1	4	2	3	2	1	3a	1	1	4	2	Epilepsy
John Smith	21091	56	1	2	2	1	2	3	1	1	2	1	2	2	

On the Profile Sheet every third dividing line is heavier in order to facilitate following the columns. It is of utmost importance that the numerical figures be placed in the proper column with meticulous accuracy. The names are listed alphabetically for easy reference. Each sheet contains space for 35 names.

In the above example the first profile reading, 11423213a1142, indicates that John Doe was admitted to the hospital in 1935 (indicated by his hospital number) at the age of 20. Physically he is able bodied. He works with minimum supervision. He takes medication regularly because of an organic illness (epilepsy). Occasionally he presents a problem in his relations with the opposite sex. He must be reminded to keep himself dressed neatly or to wash himself and keep his hair combed, but he does these things himself when he is reminded of them. He is careless with property but not deliberately destructive. Eating habits are acceptable. He has a tendency to elope from the hospital but in general his physical activity is acceptable. Habits of excretion are normal. He is aggressive towards other patients, but not assaultive and is usually cooperative with hospital personnel.

Profile, however, is necessary as part of a psychiatric evaluation.

Experience with the Philadelphia Profile has demonstrated its usefulness not only to the medical staff, but also to the nursing personnel. The supervisors who are responsible for a large number of patients, the new employees and the relief personnel who may not be familiar with the behavior of the patients under their care find it particularly helpful. When a patient is transferred from one unit to another, the Profile is helpful to those who must know his behavior characteristics. The Profile also provides information about the group behavior of the unit. A glance through the columns gives precise information about specific problems which arise on any unit. Periodic evaluations give a dynamic picture of the progress of the unit in handling an increase or decrease in specific behavior problems. The Profile also helps to promote homogeneity in classification of the patients, and to direct attention to those individuals who might be considered for placement in the community. The Profile has an additional advantage as it is suitable for use on the I.B.M. card system to compile statistics.

Figure 2

Physical Status

1. able bodied
2. physical handicap in walking or handling objects (specify—feeble, blind, loss of limb) which is not medically treatable
3. wheel chair
4. occasionally bedfast
5. constantly bedfast

Habits of Work

1. willing and able with minimum supervision
2. unable for physical reasons
3. needs close supervision (overworks or stops before completing task assigned)
4. persists in undirected activities; puttering
5. idle for psychiatric reasons

Indications for Medication or Treatment

1. none
2. occasional
3. should be brought to attention of physician for further treatment of chronic physical or mental condition (specify)
4. regularly required for organic physical illness (specify)
5. regularly required for functional psychiatric reasons (specify)

Laxity in Sex Behavior

1. none
2. occasional heterosexual problem
3. occasional homosexual problem
4. constant heterosexual problem
5. constant homosexual problem

Appearance (Personal cleanliness and dress)

1. acceptable
2. needs occasional supervision
3. needs reminding
4. needs constant supervision
5. denudative

Destruction

1. none
2. careless with property but not deliberately destructive
3. destroys clothing or linen
4. plugs toilets
5. destroys property

Eating Habits

1. acceptable
2. needs occasional supervision
3. needs close supervision
4. table manners objectionable (to best patients' standards)
5. must be fed (spoon fed or tube fed)

Laxity in other Problem Behavior

1. none
2. addiction to alcohol or drugs (specify)
3. (a) eloper, (b) wanderer
4. other (specify — unauthorized letters, "peeping tom", thievery, arson, hoarder, etc.)
5. suicidal

Physical Activity

1. acceptable
2. quiet, lacks initiative
3. restless, purposeless, confused, or showing involuntary movements.
4. negativistic, resistive, impulsive
5. (a) noisy, (b) overactive

Habits of Excretion

1. acceptable
2. needs occasional supervision
3. incontinent (due to physical disability)
4. needs constant supervision
5. excreta careless

Interpersonal Relations (with fellow patients and visitors)

1. acceptable
2. seclusive
3. will not protect self from aggression by others
4. aggressive—does not respect rights and/or property of others
5. assaultive (habitually)

Attitude towards Personnel

1. cooperative
2. usually cooperative
3. passively uncooperative
4. actively uncooperative
5. belligerent

News & Notes

SK&F Fellowship Program Expanded

The Smith, Kline & French Fellowship program has been considerably expanded this year in an attempt to further relieve personnel problems in mental hospitals. It has been broadened to cover medical students, teaching centers, general physicians, psychiatric authorities from this country and abroad, as well as state hospital psychiatrists.

The expanded program will include seven categories:

1. *Staff Psychiatrist Training Fellowships,* under which full time staff psychiatrists of public mental institutions will be given support for advanced training at psychiatric teaching centers.

2. *Awards to Hospitals for Teaching,* in which support will be given public mental institutions for full-time teaching staff members and for bringing psychiatric authorities to the institution for staff training on a visiting basis.

3. *Extension Training Fellowships,* under which medical schools and teaching centers will be aided in setting up extension training on a continued, part-time basis for public mental hospital psychiatrists.

4. *Student Fellowships,* which are offered to medical students for work in mental hospitals or psychiatric training centers during the summer prior to their senior year or during their senior year.

5. *Medical Fellowships,* for non-psychiatric practitioners to get special training and experience in a mental hospital or psychiatric teaching center.

6. *Foreign Scholar Lectureships,* for bringing outstanding lecturers to the United States and stimulating the international exchange of psychiatric techniques.

7. *Residency Training Fellowships,* for outstanding psychiatric residents dedicated to service in public mental institutions.

Fellowships are awarded by the Smith, Kline & French Foundation Fellowship Committee, which is comprised of eight distinguished psychiatrists. These are: Kenneth E. Appel, M.D., chairman, Professor and Chairman of the Department of Psychiatry, University of Pennsylvania School of Medicine; Daniel Blain, M.D., Medical Director, American Psychiatric Association; Henry Brill, M.D., Assistant Commissioner, New York State Department of Mental Hygiene; Jacob E. Finesinger, M.D., Professor and Chairman of the Department of Psychiatry, University of Maryland School of Medicine; Francis J. Gerty, M.D., Professor and Chairman of the Department of Psychiatry, University of Illinois School of Medicine; David A. Young, M.D., Commissioner of Mental Health for North Carolina; Seymour D. Vestermark, M.D., Chief, Training and Standards Branch, National Institute of Mental Health; Robert G. Heath, M.D., Professor and Chairman of the Department of Psychiatry, Tulane University School of Medicine.

September Supplementary Mailing

The Supplementary Mailing for September consists of a copy of the book "PSYCHIATRY, THE PRESS AND THE PUBLIC: Problems in Communication". This 66-page book is the Report of a Conference on Special Problems of Communicating Psychiatric Subject Matter to the public, held at Swampscott, Mass., in June 1955.

The Report explores the difficulties encountered both by psychiatrists and members of the press, and makes some suggestions as to how these two groups may work together more fruitfully. The selected list of related articles, books, documentaries and pamphlets by members of the conference are of special interest to hospitals dealing with the ever-present public relations problem.

Additional copies of the book are available from the A.P.A. Public Information Office at $1.00 each.

M.H.S. Film Library Receives Donations

Through the generosity of Wyeth Laboratories of Philadelphia, six copies of the well-known television film "OUT OF DARKNESS" have been added to the M.H.S. film library. The addition of this film brings the number of titles in the library to fifteen.

This 90-minute black and white drama shows the course of therapy between a mute schizophrenic and the late Dr. Louis Cholden. The narration is spoken by Orson Welles.

Dr. William C. Menninger, as commentator, explains something of the causes, nature and treatment of mental illnesses. The film, while originally produced for the general public, has considerable value as a training film, especially for volunteers, aides and others whose professional education has been limited.

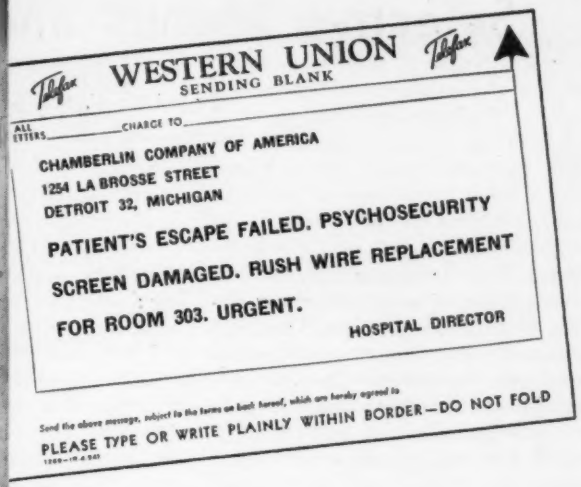
In our June issue, we announced that $2,000 had been granted to the Film Service by the Smith, Kline and French Fellowship Committee, to enable us to add further titles to our list, and to get extra copies of films now in demand, thus cutting down the waiting period.

Hospital Recreation to be Studied

The National Recreation Association is launching a nation-wide study of hospital recreation programs. Data will be collected on the number of professional recreation workers now in hospital work, their educational background and their relationship to the hospital administration.

It is hoped that the results of the study will help recreation educators plan for college courses in hospital recreation. According to the N.R.A., more than 65 colleges now offer major courses in recreation leadership, with specialization in hospital recreation available at a number of the schools. The study hopes to provide information which will help define the role of recreation for hospitalized persons.

An advisory committee for the study has been set up which includes representatives of the American Medical Association, the American Psychiatric Association, the American National Red Cross, the American Hospital Association, the Veterans Administration, the U. S. Department of Health, Education and Welfare, the National Association of Recreation Therapists, the American Recreation Society, and the American Association for Health, Physical Education and Recreation.



IN ONLY A MATTER OF HOURS CHAMBERLIN ASSURES EXPRESS SHIPMENT OF NEW PSYCHOSECURITY SCREEN PANEL ASSEMBLY. LESS THAN ONE HOUR WITH A SCREW DRIVER COMPLETES SCREEN PANEL REPLACEMENT.

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For the less violent

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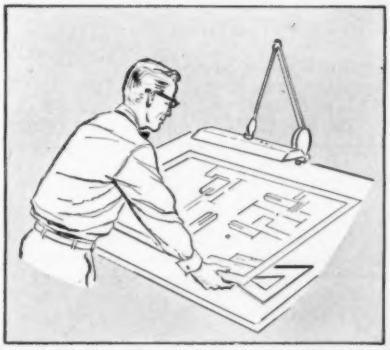
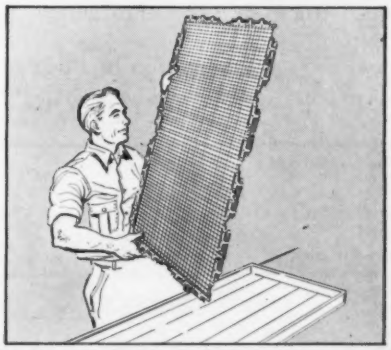
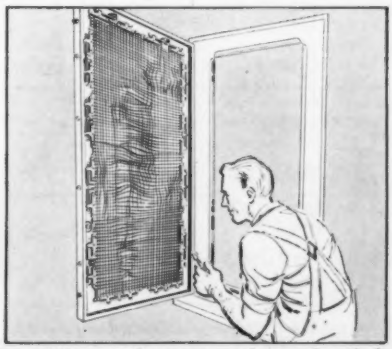


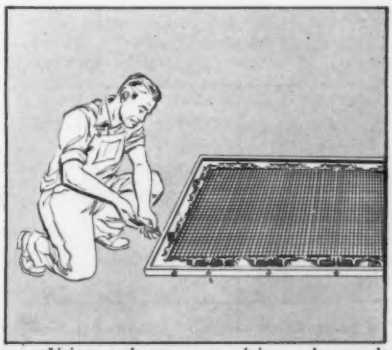
1 From shop drawings and production schedules a Chamberlin engineer determines size of screen panel replacement.



2 Replacement screen panel with all hardware applied in proper position is shipped by express.



3 When replacement arrives a hospital maintenance man simply removes hinge pins and lays swing section of unit on the floor.



4 Using only a screw driver, damaged screen panel is removed and replaced with a new panel, complete with factory-applied springs and clevises.

CHAMBERLIN INSTITUTIONAL SERVICES also include Mineral Wool Insulation, Metal Weather Strips and Caulking, Metal Combination Windows and Doors, Metal Insect Screens, Aluminum and Fiber Glass Awnings.

Two Recent Trends in Hospital Dietetics:

Selective Menus and Preportioned Meats

By MARIE W. BOLDUC, Chief, Dietetic Service
Veterans Administration Hospital, Roseburg, Oregon

IN THE PAST the hospital menu with no choice of food left many patients disgruntled, dissatisfied and discontented. For this reason selective menus have found favor in many hospitals in the last few years. This is true principally because patient satisfaction has been found to be good therapy.

Neuropsychiatric as well as general medical patients come in this category. Even though some psychiatric patients appear to live in a world of their own, they seem to have a keen sense of perception when a choice is offered.

Selective menus were initiated at our hospital in June 1955, on a trial basis. Perhaps some of the things we learned from our experience will be of help to other hospitals contemplating a selective menu plan.

At the beginning of our project, in order to make it clear to the patients that they must choose rather than take all items that appeared on the cafeteria line, the food service worker at the serving station would say continuously, "one or the other, not both." This routine was followed until the patients understood our intentions in the matter of placing different foods before them. At the present time, there are very few who take both alternatives.

It might seem that the few taking all choices would seriously disorient previous planning and disrupt the budget. As a matter of fact, however, plate waste is less with a choice and food costs do not soar—more often they are reduced.

As a pre-planning measure we made some investigative studies with choices of salads. The result of these studies gave us the per cent of acceptability and the cost of various salad combinations. Fruit salad, tossed green salad and cole slaw were the most popular. Choice was made on the basis of combinations used as well as other foods on the menu. It seemed easier for patients to choose from similar dishes such as two types of jellied salads, or from onions or relishes, rather than between onions and fruit salad.

At one meal served at the beginning of our project, a choice of onions or relish was offered and both were taken. The reason for this may have been that hamburgers were served as the entree, which led the patients to think that onions were part of the meal and that relish was a salad item. On the other hand, the fact that many commercial restaurants serve both items with hamburgers may have influenced their desire for both. Better results were obtained when we teamed onions with lettuce or other green salads.

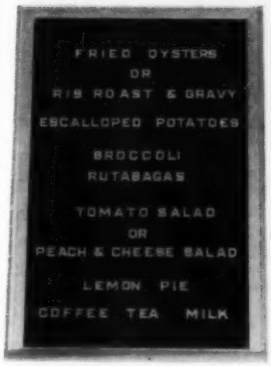
After the fact-finding period we continued with a selection of the foods used in the study. Our next investigation was on types of desserts. Again we learned that it is easier for the patient when like desserts are offered, such as two kinds of cookies, two kinds of fruit or two kinds of pudding.

It might be well to bear in mind that the foregoing incidents took place during the planning stage. Now that the patients are better oriented in the operation of selective menus, we can exercise a little more leeway on combinations. Surprise items help keep the interest in selection more keen.

Comparison of Costs of Portion-Ready Meats

ITEM	LBS. PER MEAL	MAN HRS. PREP. TIME	COST MEAT PER MEAL	COST OF LABOR	TOTAL COST
Pork Chops or Steak	270	1 Hr.	$130.88	$1.96	$132.84
Pan Ready, Boned 4 oz. portion	180	10 Min.	84.15	.35	84.50
Ham—cured w/bone	210	1½ Hrs.	108.15	2.92	111.07
Ham, boned, rolled, ready-to-eat	125	10 Min.	95.00	.35	95.35
Chicken—fryers Undissected	455	1½ Hrs.	218.50	2.94	221.34
Chicken thigh or drumsticks	250	10 Min.	185.00	.35	185.35
Carcass beef steak, oven	290	3 Hrs.	111.00	5.88	121.88
Beef Grill Steak	180	10 Min.	112.95	.35	113.30
Carcass beef Hamburger	250	3 Hrs.*	100.00	5.02	105.02
Chopped Beef Patties	180	10 Min.	61.20	.35	61.55

** The three hours time for preparation of carcass-beef hamburgers includes boning, molding and clean-up of the pattie machine; the time of two workers is included for molding patties.*



A selective menu is also offered at the Waco (Texas) VA Hospital. Patients or staff may select a meal as pictured below from the choices offered on sign.

When we came to consider offering a choice of meat—always the expensive item—the question was: "How would a choice work budget-wise?" Carcass meat seemed reasonable in price but there was the waste of bone trimming and fat. On inquiry it was found that many restaurants were now using frozen prefabricated, preportioned meat because a good product with uniform portions could be offered at less cost. The preportioned, prefabricated items that we adopted for use were chopped beef patties, beef grill steaks, pork steak, all in four-ounce portions (although they may be obtained in two- or three-ounce portions). We discovered that prefabricated meat requires less cooking time than does fresh meat cut from carcass; overcooking prefabricated meat causes dryness and undue shrinkage. It takes almost constant supervision before the habit of longer cooking is broken.

Preportioned Meats Found Versatile

All types of portion-ready meat lend themselves well to various styles of cooking. Beef grill steak may be country-fried or breaded and deep-fat fried. This type of preparation must be started while the meat is still in the frozen state. Throughout the meal period only enough meat is cooked to keep hot meat continuously on the serving line. No product is prepared with entirely defrosted meat.

The beef grill steaks may also be barbecued or served Swiss style. Swiss steaks are prepared by undercooking frozen floured prefabricated steak on the grill, arranging in baking pans and covering with a small amount of gravy and sauce. Then these are oven-processed at low temperatures for one hour. This process gives a Swiss steak appearance with a minimum of oven time.

We also have adopted the use of pre-cooked ham, boned and rolled, in casings, and chicken parts (drumsticks and thighs provide the best portions for our needs). The ham is sliced by machine and laid on bun pans. At serving time, a five-minute period in the oven is all that is necessary. It is preferable that the steam be locked in the ovens to keep the ham moist.

Square-cut chunk meat has proved economical for stews, roasts and similar dishes, since it gives a maximum of meat with a minimum of bone and trimming.

A quick resumé of budget benefits for one meal using preportioned meats as compared with regular cuts, is given in the accompanying chart.

The shorter cooking time is also a money saving factor; then too, cooking space is increased: when a grill full of steaks can be broiled in five minutes, where previously it took ten, you have doubled your cooking space.

So far it has not been practicable at this hospital to extend the selective menu system to all ward dining rooms. Only patients fed in the main dining room and the personnel are on entirely selective menus, but a choice of vegetables, salads and desserts is now offered in one ward dining room.

The primary benefit of a selective menu system is to the patients. Choice of food gives the patient a certain feeling of freedom and independence within his confines. He becomes happier when he knows he need take only what he chooses.

THE PATIENT DAY BY DAY

Canteen Profit Used For Patient Welfare

Following the lead established by many state hospitals, State Hospital South, Blackfoot, Idaho, some years ago refinished the basement in the Central Building into a very large Canteen and Commissary. This has provided a profit of $300 to $400 annually which can be used for patient welfare. The PBX board is situated in the Canteen and is operated by a paid employee. Patients operate the Canteen, which is open 24 hours a day.

Home Economics Classes Give Dinner Parties

The three home economics classes at Rainier State School, Buckley, Wash., wound up the school term by preparing and serving dinner parties for several school groups. The girls' and the boys' basketball teams were each honored at dinners, the school teachers were given a luncheon, and a "pancake feed" was held for the children of the school's Cerebral Palsy Center. The girls then turned their talents to their own enjoyment by planning a party for themselves, to which they invited the younger girls who were receiving simpler housekeeping training.

Library Periods Feature Reading Aloud Sessions

All mental hospitals have patients who rarely or never read a book or magazine. Older patients may have poor eyesight; others are too withdrawn. We have found that reading aloud brings rewarding responses from many patients at the VA Hospital, St. Cloud, Minn.

As a ward group enters, the librarian invites patients to sit in on reading sessions at one end of the library and displays the material for that day. Those not interested may read or look at slides elsewhere in the room. Aides help in getting groups together and easing out any patients who may be too restless that day.

The roll of usual attenders is called so that I can know the patients better. (I may later look up case histories to decide what kind of material would be most interesting to the group.) Non-fiction such as: *Treasury of Railway Folklore, Monster Midway* (circus and carnival), *Hinckley Fire, Hunter* (killing of a rogue elephant), *Tales of the Wild West,* and sea stories, are most satisfactory.

The reading hour is broken up by informal discussion. Often one or two patients will try to monopolize the discussion and the moderator must resume reading tactfully or draw others into the conversation. The material must be read over in advance so that offensive material or dull passages can be deleted. Alternative stories should be handy in case one does not "go over."

ELEANOR L. JOHNSON
Medical Librarian

Photo courtesy of Minneapolis Star

Collie Classes Held at Anoka State Hospital

For the past two years a class on dogs has been conducted weekly by Mrs. Leonard Cohen of Minneapolis, a collie breeder who serves as a volunteer worker at Anoka (Minn.) State Hospital. The class is limited to twelve patients.

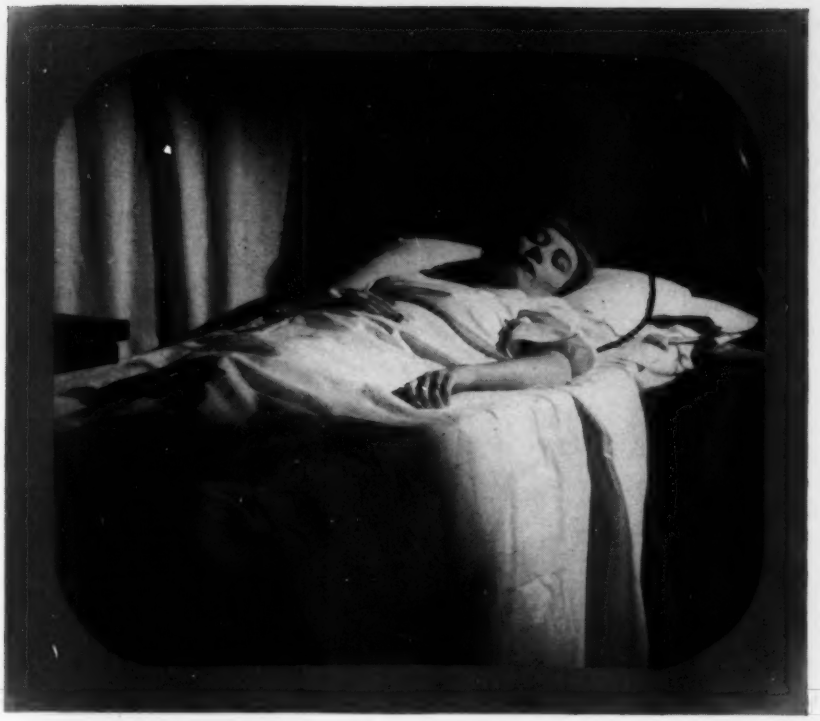
One or two collies at a time are brought out to the hospital and class conversation centers around the visitors of the day. Puppies are brought at five weeks of age and present a playful object for discussion. As the dogs grow and change another puppy is introduced.

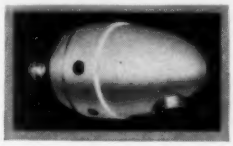
Every session begins with a half hour discussion of some phase of dog life and its influence on human life. The balance of class time is generally used by patients talking about dogs they have owned or known.

Patients' Council Subscribes To MENTAL HOSPITALS

The Patients' Council at Patton (Calif.) State Hospital has purchased 45 one-year subscriptions to MENTAL HOSPITALS so that a copy may be placed on each of the hospital's units. The purchase was made with an appropriation from the Patients' Benefit Fund after the Patients' Council expressed unanimous approval of the magazine. The Council devoted one of its meetings to a discussion of "The Role of the Hospital in Psychiatric Public Relations", which appeared in the February issue of MENTAL HOSPITALS.

A survey of a number of the units showed that the patients took a great interest in the publication, particularly those on the acute treatment wards. The ward personnel feel that the magazine answers many of the patients' questions about mental hospital treatment and operation, and thus saves the staff many hours of explaining.



with GPL  *HOSPITAL TV*

one nurse observes a dozen patients *in seconds*

By just flicking a switch, a nurse can keep an eye on all patients—in private rooms and in wards—when her floor is equipped with GPL *ii-TV*. The bright, clear pictures that GPL's *industrial* and *institutional* television system brings to the receiver on her desk give her bedside reports as often as she needs them. Both improved patient care and staff efficiency are gained with this revolutionary, visual communications tool.

The small *ii-TV* camera, weighing only five pounds, is easily moved wherever needed. Yet it is so sensitive it gives fine pictures despite the low light level of hospital rooms. The camera can be equipped to sweep a whole ward, to operate from remote control, to supply a close-up at will.

Any number of rooms can be put on an *ii-TV* circuit and nurses can operate the entire system. Maintenance is simple. Initial cost is low.

Patient observation is only one of the many hospital jobs *ii-TV* can do. A GPL *ii-TV* System makes it possible to keep records in a remote basement, yet visually accessible, instantaneously. Students and trainees, watching on an *ii-TV* monitor, get a far better view of treatments, an operation or a teaching demonstration than they can when watching through a porthole, or in a classroom or operating theatre. Tie a GPL TV projection set into the *ii-TV* circuit—as a Midwest mental clinic has done recently—and a whole auditorium can watch larger-than-life pictures on a wall-size screen.

GPL *ii-TV* is also invaluable in keeping an eye on entrances, corridors, storerooms. The GPL camera will keep unceasing watch at key points and report to a central monitor.

Behind *ii-TV* are the skill and experience which have made GPL one of the country's leading manufacturers of broadcast, theatre, military and industrial TV equipment. The same design skill, high quality material and precision manufacture go into the GPL *ii-TV* System.

For more information as to how your hospital can use GPL *ii-TV* to improve both patient care and operating efficiency, write:

General Precision Laboratory Incorporated
Pleasantville, New York

A SUBSIDIARY OF GENERAL PRECISION EQUIPMENT CORPORATION

The Patient Day by Day

(Continued from page 18)

State School Minstrel Show Makes Road Tour

The All-Boy Minstrel Show presented by the Mansfield (Conn.) State Training School gave five performances this year. The show, which has been presented annually since 1948, was given three times at the school, for patients, employees, parents and friends. The following week the cast traveled to the state hospitals at Norwich and Middletown to perform for their patients and employees.

Although only boys take part in the show itself, girl patients assist in making costumes and scenery.

Enclosed Courtyard Permits "Open" Recreation Program

Minnesota's Sandstone State Hospital, is housed in a former Federal prison, which the state leased in 1950. It now houses 440 patients, all men, of whom 360 are mentally ill, 40 alcoholic, and 40 mentally defective.

The two-story building surrounds a large courtyard, 385 feet long and 282 feet wide; all wards and service units, except the boiler room, open onto the yard. This factor, plus the fact of an all-male population, has permitted us to conduct an "open" recreation program. The ward doors are open from 7 a.m. to 10 p.m., except during bad weather when closer supervision is required. Activities are scheduled and all patients are informed; they may participate or not, as they wish. It is necessary, however, to bring some of our more regressed patients to the activity and insist on participation, but the general rule is voluntary participation.

This is particularly effective with the handicraft program. The shop door is left open at all times that a staff member is on duty, and the patients come and go as they please. Many patients wander in and watch over a period of several weeks and, without any pressure from the staff, decide to start in.

This system does away with most of the need for escort service. We feel that the therapeutic value of our activities program is increased by the fact that the men can attend by themselves rather than being taken in a group. They may also leave the dance, bingo party, or other social event, when they wish, and we find this provides a good means of evaluating our program. If participation in a certain activity is poor, we know that we must consider improving or eliminating it.

When the hospital was first opened, the courtyard was graveled and had a softball field. We soon discovered that the gravel made the courtyard warmer on hot days and dusty on windy days. Another disadvantage was that when games such as softball or volleyball were played, some of our more psychotic patients would wander onto the athletic field and were in danger of being injured. Thus we covered the yard with black dirt and planted grass and moved the athletic field outside the building. We hope eventually to put in a black-topped area in one corner of the yard for a games area, and make the rest of the courtyard a large park with trees and benches.

The courtyard system does have several disadvantages. The 40 mentally deficient men are the most difficult to cope with, since many of them will not stay properly dressed and some of them have homosexual tendencies. I would very strongly suggest that there be a smaller enclosed yard for patients that need to be separated from the other patients and screened from visitors. Another problem is with some patients who are not rational enough to protect themselves from the sun; every spring a number of men gets a bad sunburn despite the staff's watchfulness.

On the whole, however, we feel that the courtyard has been beneficial in permitting us to carry on a voluntary activities program.

JAMES R. KOUGH, Supervisor
Rehabilitation Therapies

Dietary Department Shares in Training Program

Students who work in the kitchens and dining rooms at the Parsons (Kans.) State Training School not only learn food preparation and serving, but also receive instruction in nutrition. Charts and posters and words shown with an opaque projector help the students to recognize and pronounce words used in the dietary department. Classes are so popular that there is frequent volunteer attendance by students not assigned to the kitchens or dining rooms.

HOWARD V. BAIR, M.D.
Superintendent

College Girls Perform Varied Volunteer Services

For the past six years groups of first- and second-year psychology students at Cottey College (for women) at Nevada, Missouri, have been volunteering their services to the Missouri State Hospital at Nevada. The girls spend three hours every Monday morning, when no regular classes are held at the college, providing entertaining or instructive projects for the patients. Both the girls and the patients can choose the type of activity they wish to undertake.

Some of the more popular activities are finger painting, ceramics, leather work, sewing and similar handicraft work, cooking, group singing and square dancing. The students work under the direction of the hospital's clinical psychologist. Some of them have become interested in taking up a career in some branch of therapy, such as music or occupational therapy.

A quartet of Cottey girls serenades patients to auto-harp accompaniment.

No. 10 in a Series on Mental Hospital Administration

BUSINESS AND FINANCE MANAGEMENT

Including requisitioning procedures, allotment procedures and policies

By F. A. MATHESON, Business Manager
Provincial Mental Health Services, Essondale, British Columbia

THE BUSINESS AND FINANCIAL MANAGEMENT of a large public mental hospital is an important and complex phase of the operation. The Business Manager should be responsible to the Director or Medical Superintendent for certain specific operations of the hospital. These can be roughly stated under three major headings—the feeding, housing and clothing of the patients.

In a hospital taking care of some 6,000 patients with a staff of over 2,000, a not unusual size, it becomes apparent that the problems connected with the feeding, housing and clothing of the patients and of a large portion of the staff, who must also be fed, housed, and supplied with uniforms, requires a most efficient organization if the patients are to receive the care they are entitled to, and if the taxpayer is to receive value for the funds expended.

One of the first and possibly most important controls in the financial management is the annual budget. The preparation of the budget has been very ably dealt with by Dr. Jack R. Ewalt in the May 1956 issue of MENTAL HOSPITALS and I would recommend it for study by all mental hospital administrators. I will not deal further with the budget other than to re-emphasize the fact that it should be to a certain degree flexible. The care of the mentally ill is not static in this day and age. New therapies are continually being discovered; these should be available as soon as they come on the market even though they have not been specifically provided for in the budget. However, a properly thought-out and prepared budget is the main control in the financial operation of the hospital and must be adhered to as closely as possible if proper control of expenditure is to be maintained.

The stores department is another very important factor in the financial control of a mental hospital. We have found it advantageous to divide our stores department and our stores accounting into two separate departments, each responsible to the Business Office.

The stores department is responsible for the ordering, receiving and issuing of all supplies and for maintaining bin card records of receipts and issues in quantities only. The stores accounting office is responsible for the passing of invoices for payment, from information and records received from the storekeeper. Some hospitals also maintain stock control cards that show not only receipts and issues, but also unit prices, value of all receipts, issues, and stock on hand. If the control cards are continually checked against the stock any differences will be discovered almost immediately. Monthly reports showing the inventory at the start of the month, receipts and issues during the month, and balances in quantities and dollar values under the various headings are submitted to the Business Office.

In order that the storekeeper may be in a position to carry out his responsibilities properly, all requisitions for supplies and equipment to be purchased should originate in his department and all deliveries from the suppliers should be made, wherever practical, to the stores. Where it is not practical to deliver supplies such as coal, large quantities of furniture, gasoline, etc., direct to the stores, the records of both receiving and issuing such supplies should, nevertheless, be kept by the stores department. This system makes the storekeeper responsible for ordering, receiving and issuing all supplies.

The storekeeper may operate five chief sub-departments as follows: dietary; ward supplies; uniforms and clothing; hardware and crockery; and medical supplies. Printed and numbered requisition forms, punched for peg-board recapping, are used for each separate department. These requisitions, prepared by the ward, kitchen or department requiring supplies, are approved by the department head before being forwarded to the storekeeper. He examines the requisition and if it meets with his approval the supplies requested are authorized. If, however, there is anything on the requisition that he does not feel is justified he may contact the department head for further explanation. If, after receiving the explanation, he is still not satisfied, the matter may be referred to the Business Office for ruling before the supplies requested are issued. This procedure tends to reduce unreasonable requests and greatly assists in the control of expenditure.

Requisitions for drugs, instruments and surgical supplies should be submitted direct to the Chief Pharmacist, who handles them in the same manner the storekeeper handles requisitions for other goods.

At the end of each day the requisitions filled by the stores department are recapped and the issues recorded on the bin cards. The requisitions, together with the recaps, are then handed to the stores accounting office, where at the end of the month the recaps are summarized and priced and the issues for the month recorded on the stock control cards. Such records also supply the infor-

mation for the monthly report previously mentioned that is submitted to the Business Office.

A disbursement synoptic, which records all expenditures under various headings such as office expense, medical care, dietary, etc., shows the monthly expenditure, while the record of store issues, plus salaries and other service charges, provides complete figures on costs. These figures, covering both expenditure and usage, can be checked against the monthly budget appropriation. Thus the Business Manager is able to identify overexpenditures under any section of the appropriation and to keep a month-by-month control on both expenditures and stores inventory.

At one time standard allotments for wards were the main control for the operation of a mental hospital. Under this system each ward was allowed a certain number of basic items for each patient. With modern advances in treatment, however, ward requirements differ tremendously and this must be taken into consideration when making allotments. Care must also be taken, as treatments and conditions on a ward change, that set allotments do not hamper the treatment of the patients.

In summarizing it will be noted that the annual budget is the basis for exercising control of expenditure but that valuable assistance in this control can be gained by authorizing the storekeeper to question and receive full explanation before filling requisitions that, in his opinion, may not be justified. Monthly reports of both expenditure and usage are vital if a balanced budget is to be achieved.

ED NOTE: Copies of the business forms used at the Provincial Mental Hospital at Essondale are available on loan from M.H.S. (see page 25).

Disaster Planning in Mental Hospitals

C.I.B. Recommends Action Plan

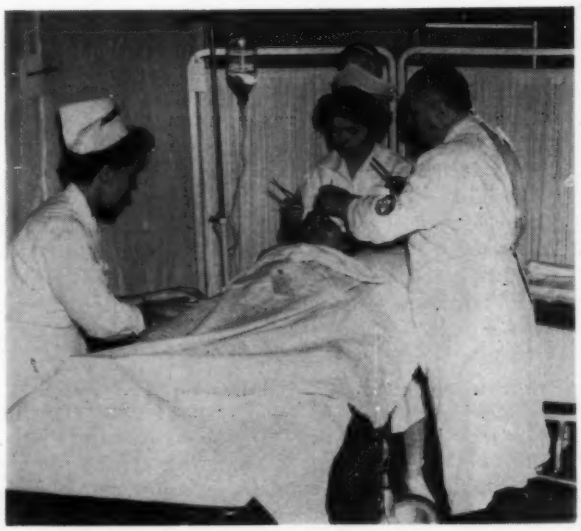
THE NEW STANDARDS of the Joint Commission on Accreditation of Hospitals recommends that each hospital have a disaster plan. The A.P.A. Central Inspection Board will similarly recommend to the hospitals it inspects that they formulate and publish a plan of action in case of either natural disaster, such as tornado, hurricane or flood, or a man-made disaster such as atomic bombing.

A written plan is useless unless the people who are to carry out the plan have sufficient training and hold regular drills which deal with simulated disasters. Hospitals should coordinate their efforts with local civil defense programs. If properly planned programs are set up and personnel are trained to carry out the plan, the mental hospitals of the United States and Canada could provide a backlog of available beds which would not be available in general hospitals. The fact that most mental patients are not bedfast and can put up with inconveniences, if necessary, should make it possible for most mental hospitals to make at least 25% of their beds available in an emergency. Many general hospitals are located in centers of population and might be put out of commission in case of disaster. Most mental hospitals, on the other hand, are in less populated areas that are not likely to be damaged.

The training of auxiliary personnel in first aid and the handling of casualties will not only be a morale builder but might also uncover hidden abilities in many employees. If a disaster should occur, the ability to perform duties above and beyond those regularly assigned may be of invaluable help.

CHARLES K. BUSH, M.D., Chief Inspector
A.P.A. Central Inspection Board

Mental Hospitals throughout the country are including Civil Defense maneuvers as part of their general safety programs. We present here a look at some of the preparations made by institutions.



A "bombing casualty" is treated by staff members of the Central Islip (N.Y.) State Hospital who took part in county Civil Defense exercises.

Above: the control center is the keystone of Greystone Park (N. J.) State Hospital's system. Key personnel are shown at their posts during a state-wide drill.

Below: Litter bearers rush a "casualty" to safety during a disaster drill at Springfield State Hospital, Sykesville, Md. Forty observers from State and local defense agencies, the Department of Mental Hygiene and other institutions were on hand to watch.

M.H.S. Loan Volumes on Disaster Planning

Please enclose 10¢ for each volume requested to cover postage and handling.

Disaster Plan, VA Hospital, Salisbury, N. C.

Civil Defense & Disaster Plan, Greystone Park (N.J.) State Hospital

Disaster Control Operation Plan and Fire Bill, Springfield State Hospital, Md.

Warren's Disaster Plan Proves Value in Flood Crisis

Warren State Hospital is located in a somewhat isolated rural area of northwestern Pennsylvania. The hospital had worked out a disaster plan at the request of the local Civil Defense agency, but felt it would be put to use only if Pittsburgh, Erie, or some other city in its vicinity should be bombed severely enough to require aid from as far away as Warren.

Last March, however, disaster struck unexpectedly at home when the Allegheny River went on an unprecedented rampage and caused critical flooding of the Warren community.

The state hospital is fortunately located on high ground, and escaped the deluge. In the town itself, however, within a few hours many hundreds of families were homeless and the Warren General Hospital was flooded so badly that it had to evacuate its patients. Only thirty-one heart patients, considered too ill to be moved, remained at the general hospital. Under Civil Defense direction the other seventy-nine patients were taken by truck to the state hospital.

The state hospital, which had been notified at 8:30 a.m. of the general hospital's decision to evacuate and had offered refuge, was meanwhile putting into effect the disaster plan it had been practicing for the previous ten months. Within an hour the 200 patients of its medical-surgical unit had been transferred to previously designated wards in other buildings. Had even quicker abandonment of the unit been required, the hospital was prepared to give emergency shelter to its medical-surgical patients in the auditorium-gymnasium building. But the transfers proceeded so smoothly, thanks to the foresighted planning and drills, that the medical-surgical unit was in readiness for the general hospital evacuees well before they arrived.

The medical-surgical building, which is an essentially self-sustaining unit with complete surgical and kitchen facilities, was staffed during the week that it sheltered the general hospital patients with physicians, nurses and aides provided by the community.

The added crowding on the other wards where the transferred patients were assigned (the hospital has a rated capacity of 2500 beds and a patient population of 3200) did cause some discontentment and confusion. There were, however, no major problems arising from the situation during the week of emergency.

Dr. Robert H. Israel, Superintendent of Warren State Hospital, reports that they were, of course, greatly relieved that advance plans had been worked out in such careful detail. "It appears to us," Dr. Israel writes, "that the state mental hospitals have a tremendous value as a resource to be used in event of civilian disaster. All large mental hospitals, like our own, have numbers of separate buildings, some of which are self-sustaining insofar as medical and food preparation facilities are concerned. I am sure, also, that mental hospitals which depend so much on their communities for help in mental health programs will welcome the opportunity to aid them in event of an emergency."

PROGRAM TOPICS AND LEADERS FOR EIGHTH MENTAL HOSPITAL INSTITUTE

HOSPITAL ATMOSPHERE IS A DEFINITE TREATMENT MEASURE
Edward Stainbrook, M.D., Los Angeles, Calif.

STAFF RELATIONSHIPS AFFECT HOSPITAL ATMOSPHERE
Alfred H. Stanton, M.D., Boston, Mass.

STAFF ACCORD MUST BE REACHED TO ATTAIN HOSPITAL OBJECTIVES
Esther Lucile Brown, Ph.D., Boston, Mass.

TREATMENT DOES NOT CEASE WITH DISCHARGE
Dr. Thomas J. Boag, Montreal, Canada.

INFORMATION AND COMMENT SESSION
C. K. Bush, M.D., Washington, D. C.

TRAINING STAFF TO GIVE GOOD FOOD SERVICE
Mrs. Cora E. Kusner, Pueblo, Colo.

MEDICAL RECORDS AND RECORD KEEPING
Mrs. Cleo Nelson, C.R.L., Los Angeles, Calif.

CHILDREN AND ADOLESCENTS IN THE ADULT INSTITUTION
Robert S. Garber, M.D., Princeton, N. J.

RESEARCH AS A PART OF EVERY HOSPITAL PROGRAM
John E. Davis, M.D., Philadelphia, Pa.

HOW PERSONNEL POLICIES CAN ASSIST IN THE MENTAL HOSPITAL
Eugene Pawl, New Castle, Ind.

NURSING CARE ON THE WARD LEVEL
Miss Garland K. Lewis, R.N., Seattle, Wash.

CARE OF THE "CRIMINAL INSANE"
Addison M. Duval, M.D., Washington, D. C.

TRANSLATING MEDICAL NEEDS INTO HOSPITAL BUILDINGS
Joseph E. Barrett, M.D., Richmond, Va.

ACADEMIC LECTURE: **"THE SCIENTIFIC ATTITUDE IN THE EVALUATION OF NEW DRUGS, WITH SPECIAL REFERENCE TO THE TRANQUILIZING DRUGS"**
Stewart Wolf, M.D., Oklahoma City, Okla.

BUDGETING PROCEDURES
Jack R. Ewalt, M.D., Boston, Mass.

POST-HOSPITAL CARE
Nathan Sloate, Sacramento, Calif.

STATE, PROVINCIAL AND PRIVATE PROGRAMS FOR THE AGED
S. D. Pomrinse, M.D., Washington, D. C.

The closing date for pre-Institute enrollments is September 24th, and already over 120 applications have been processed. The Shirley-Savory Hotel, Denver, will confirm all hotel reservations as they are received from this office.

Social Psychiatry—New Techniques

We have seen, during the past few years, the evolving of a distinct treatment philosophy in our mental hospitals—the development of a system that can be called social psychiatry.

Illustrative of this philosophy are such developments as an increasing number of patients on open wards; patient-government councils; an emphasis on home-like rather than institutional surroundings; patient case conferences, in which the entire staff from doctor to aide and even volunteers participate; and the constant endeavor of all staff members to improve their own inter-relationships in order to create a more tranquil and truly supportive atmosphere for the patients.

A number of writers have pointed out its striking resemblance to "moral treatment"—the leading form of hospital treatment a hundred years ago. While basically there are great similarities in philosophy and in operation, different techniques of application are called for because of the differences wrought by the last hundred years in our entire culture as well as in our mental hospitals.

With the help of social scientists, those who work in mental hospitals have come to understand the importance and treatment values of such concepts as role, status, hierarchy, communication, power and authority. Recent research studies have shown how these concepts in practice materially affect the treatment of patients, the morale and effectiveness of staff and the entire administration of the hospital.

A growing number of American psychiatrists have visited mental hospitals in western Europe, particularly in England and Holland. They report the actual operation of open mental hospitals under administrative regimes quite different from those current in North America. Moreover, it is apparent that these European regimes appear to offer additional benefits to patients and staff. Despite the differences in our national culture, there is evidence that mental hospitals on this side of the ocean are attempting to follow in the direction of open hospitals.

Another interesting development is

the growing integration in this country of the mental hospitals and their surrounding communities to furnish a comprehensive system of psychiatric care through the use of day and night hospitals, outpatient clinics, half-way houses, sheltered workshops and other types of facilities, all of which have as their ultimate aim, *return* to the community or actual *avoidance* of hospitalization.

A number of American hospitals have pioneered in these techniques and have learned through study as well as through trial and error the benefits which accrue. The Eighth Mental Hospital Institute offers a forum for the exchange of information about these new developments.

There will be opportunity also to discuss the newer drug therapies, as well as the recurring administrative problems basic to the operation of any mental hospital, open or closed. New developments in the care of the aged and of the criminally insane are also included as being two of the most pressing problems we face today.

LUCY D. OZARIN, M.D.,
Chairman, Program Committee
Eighth Mental Hospital Institute

Institute Highlights

The Washington staff of the A.P.A. Mental Hospital Service is already busy processing the early registrations for the Eighth Mental Hospital Institute, to be held in Denver, Colorado, from October 8th to 11th.

A sizable percentage of people have booked their hotel rooms from Saturday, October 6th, to enable them to attend the optional meetings scheduled for Sunday, October 7th. If you wish to be present on Sunday, this is worth remembering.

While there are plenty of good hotel rooms available, it is also well to remember that, since they are assigned on a "first come, first served" basis, you are likely to get better accommodations if you register as early as possible.

The Business Manager's Meeting is scheduled tentatively to begin at 12:30 on Sunday, October 7th, with a Dutch Treat Lunch. This will be followed by an afternoon discussion for as long as the group desires. This meeting is open to all who work in hospitals or state offices on the administrative side. Early registrations indicate that from 35 to 40 people are likely to attend. No formal agenda is being developed, but one of the group will act as Chairman to call the meeting to order, and to guide and stimulate informal discussion on any topics the group elects.

New Discussion Leaders

Two new Discussion Leaders have joined the Faculty. One is Dr. Esther Lucile Brown, now of the Boston University School of Nursing, where she is Director of University and Community Relations. Dr. Brown is leading Topic 3, on Staff Accord. Dr. J. R. Gibb, who was originally scheduled to lead this topic, has accepted a new position, and accordingly had to withdraw from the meeting; it is hoped that we may have his able assistance some other year.

Dr. S. D. Pomrinse will be the leader for Topic 17, on Programs for the Aged. Dr. Pomrinse, who is Chief, Health of the Aged, in the Chronic Diseases Section of the U. S. Public Health Service, was Chairman of the Health Planning Commission at the Federal and State Conference on Aging, held in Washington, D. C. last June.

Considerable interest has been shown in the discussion on the Saskatchewan Plan scheduled as an optional meeting for Tuesday evening at 8 p.m. Almost one-third of those who have already registered are planning to attend.

Awards and Entertainment

The Achievement Award this year goes to the VA Hospital at Fort Lyon, Colorado, a happy coincidence because it will enable a large number of the hospital's staff to attend when the plaque is presented to Dr. Howard P. Morgan, the Manager.

Dr. Morgan has kindly offered music during dinner by his patient-orchestra, and this entertainment will be followed by the Lakota Indian Dances. A twenty-minute program will be presented by from 20 to 25 people, and the dances will vary from serious ceremonials to humorous numbers.

There will be no Ladies' Committee this year, but the Denver Convention and Visitors Bureau is prepared to arrange tours of scenic and historical spots both in the city and the very beautiful surrounding area. The Registration Desk for the Institute will be happy to give any information about such facilities. Wives of the delegates are also welcome to go along on the local hospital tours scheduled for Wednesday, October 11th, in the afternoon.

Local Hospital Visits

Among other things, the very active Local Arrangements Committee, under the co-chairmanship of Dr. Herbert S. Gaskill and Dr. Frank Zimmerman, has arranged for a limited number of people to go to the Emory John Brady Hospital in Colorado Springs or to the State Hospital, at Pueblo. The four local hospitals to be visited Wednesday afternoon are the Denver General Hospital; Veterans Administration Hospital; Fitzsimons Army Hospital; and the Colorado Psychopathic Hospital.

A hardy perennial among optional programs is Alex Sareyan's showing of mental health films; he will start these showings early every morning, and coffee and doughnuts will be served to those who attend. He will also have a showing on Wednesday afternoon for delegates who do not wish to visit hospitals.

Loan Library Additions

Please enclose 10¢ for each one-pound volume and 14¢ for each two-pound volume to cover postage and handling.

MEDICAL RECORDS AND ADMINISTRATIVE PROCEDURES

Statistical Reporting Procedures & Suggested Record-Keeping Procedures for Community Outpatient Psychiatric Clinics *(Calif. Dept. Mental Hygiene)* *1 lb.*

Manual of Reception Services Procedures *(N. Y. State Dept. Mental Hygiene)* *1 lb.*

Procedural Memoranda & Charts *(Galesburg State Research Hosp., Ill.)* *2 lbs.*

Requisition & Stores Record Forms *(Provincial Mental Hospital, Essondale, B. C.)* *1 lb.*

MENTAL DEFICIENCY

Policies, Programs and Possible Future Plans for the Mentally Retarded in the ten Northeastern States *(M. A. Tarumianz, M.D.; H. A. Davis, Ph.D)* *2 lbs.*

DEPARTMENTS

New York to Operate Two Day Care Centers

The first of two day care centers to be operated on a pilot basis by the New York State Department of Mental Hygiene was opened in July at the Hudson River State Hospital, at Poughkeepsie. The second day hospital is expected to open in the near future in connection with the Brooklyn Aftercare Clinic.

The Hudson River day center occupies a wing of a new treatment building. The ground-floor wing has a separate entrance and forms a self-contained unit. It consists of sixteen rooms providing a ten-bed treatment unit, an occupational therapy studio, a library, a recreation room, treatment rooms, offices and dining facilities.

The program is carried on five days a week, from 8:30 a.m. to 4 p.m., and accepts patients eighteen years or older, on a voluntary basis. All standard therapies are used, including drugs, electroshock and insulin. Referrals come mainly from community physicians and social agencies; patients on provisional release from the state hospital also may be accepted.

The center is administered by a staff of fourteen, headed by Dr. O. Arnold Kilpatrick, director of the Hudson River State Hospital. The staff includes a psychiatrist, two nurses, a social worker, an occupational therapist, a recreation worker, two male and four female psychiatric aides, and a secretary-receptionist.

Employment of Ex-Patients To Be Surveyed

A study of employer attitudes in the hiring of former mental patients is being conducted by the Massachusetts Association for Mental Health in conjunction with the Office of Vocational Rehabilitation of the U. S. Department of Health, Education and Welfare. The survey will cover the practices and attitudes not only of employers but also of their employees, of industrial physicans and of placement personnel.

Some 200 employers in the Greater Boston area will be interviewed by trained investigators. The sample is limited largely to firms which have over 100 workers and which are representative of local industries.

It is hoped that the results of the study will provide the basis of an educational program to enlarge employment opportunities for recovered mental patients.

Receptionist Handles Physicians' Appointments

State Hospital South, Blackfoot, Idaho, for the past two years has maintained the position of Receptionist to keep appointment schedules for the psychiatrists in much the same way that it would be done in private practice. This system has worked out admirably. Each doctor receives both patients from the wards and outpatients by appointment at his office in the Central Office Building. Based upon the appointment record, charges are made for the doctors' services.

Public Health Nurses View Hospital Program

A four-day orientation conference for public health nurses was held at Lakin (W. Va.) State Hospital in June. The meeting was attended by about fifteen public health nurses from various counties in the state. The conference was designed to increase the nurses' understanding of mental illness and of the hospital's program. In West Virginia the public health nurses are frequently called upon to contact the families of mental patients and to make follow-up visits to patients released on medication.

The conference program, which was arranged by Lakin's Clinical Director, Dr. Mildred M. Bateman, covered all aspects of hospitalization from admission to discharge. Various members of the hospital staff were called upon to explain and demonstrate their roles in the treatment program.

"THE AMERICAN SCHOOL OF PSYCHIATRY"
Theme of the Fourth Annual Psychiatric Institute,
New Jersey Neuro-Psychiatric Institute,
Princeton, N.J. Sept. 19th, 1956.

Simultaneous Papers (Morning)

The Era of Group Psychotherapy ..... S. R. Slavson, Ph.D.
The Era of Community Mental Health .... Paul Lemkau, M.D.
The Era of Research .... Jacob Finesinger, M.D., & Edwin F. Gildea, M.D.
The Era of Religion & Psychiatry .... Rev. Thomas V. Moore

General Meeting (Afternoon)

Summation of morning papers.
The Era of American Adaptations of Psychiatric Concepts .... Oscar Diethelm, M.D.
The Era of Psychobiology ..... Wendell Muncie, M.D.

DINNER MEETING AT THE PRINCETON INN

V. Terrell Davis M.D., Presiding.

Address by Russell G. Oswald, M.S.W.:
The Era of Psychiatry in the Correctional Field
Moderators: Manuel M. Pearson, M.D., Mike Gorman, Nolan D. C. Lewis, M. D., Kenneth E. Appel, M.D., John A. Rose, M.D.
Registration fee $2. Dinner tickets $5.00. Applications for advance registration should be made to Robert S. Garber, M.D., Medical Director, New Jersey Neuro-Psychiatric Institute, Box 1000, Princeton, N. J.

Private Hospital Gives Employees Free Insurance

All full time, regular employees of the Norways Foundation Hospital, a 68-bed private psychiatric hospital in Indianapolis, have been issued a $1,000 life insurance policy. The entire cost of the premiums will be paid by the Hospital, and all eligible personnel will be automatically covered after three months' employment.

The policy provides a death benefit of $1,000 for beneficiaries, a permanent and total disability benefit, and an accidental death and dismemberment benefit.

Medical Advisory Group Helps Solve Diet Problems

The solution of dietetic problems in a psychiatric hospital often requires the cooperation of all departments directly concerned with patient care. To accomplish this, the VA Hospital at Montrose, N. Y., has created a Medical Advisory Committee to assist the Dietetic Service. The Committee has as regular members the Chiefs of the Medical, Surgical, Tuberculosis, Continuous Treatment and Dietetic Services. Representatives of the Nursing, Special Services, Canteen and other services are invited to attend as needed.

The Committee meets whenever several problems have accumulated. Its authority is purely advisory. The findings and recommendations are submitted to the Director of Professional Services for appropriate action.

The committee has suggested procedures to help combat the three major dietetic problems: inadequate and excessive eating and failure to adhere to modified diets. It also has called the staff physicians' attention to the indiscriminate prescription of special diets; the common error of forgetting to discontinue special diets when no longer indicated; the more effective and economical prescription of vitamin preparations in place of "high vitamin diets"; the use of water instead of fruit juices or milk for "forced fluid intake"; and to similar practices which make for a more efficient and effective nutrition program.

ALLAN E. HUSSAR, M.D.
Chief, Medical Service
JEAN E. STURDEVANT, B.S.
Chief, Dietetic Service

Master Control Center for Wired Music System

This Master Control, situated in the recreational therapy center of the Provincial Mental Hospital, Essondale, B. C., was designed and built by a former director of the Audio-Visual Department. The system is remarkably versatile. It may be adapted to all present day live and recorded mediums of entertainment. Twelve program sources are available to each of the four output channels. The sources include 4 radio receivers, 4 record players, tape recorders, motion picture sound tracks, live talent shows from the stage of the recreation hall and the Hammond organ in the recreation hall. In addition the Master Control can cut into any or all output channels with local hospital announcements.

Time Clocks Operate Radios Automatically

The panel is operated by non-technical personnel. Time clocks turn on the radios before the staff arrives in the morning. Similarly the time clocks turn off the radios in the evening at lights out although the staff of the audio-visual department have gone home much earlier.

Special quiet music is played over one channel in the evening by the padre in a local program known as The Angelus.

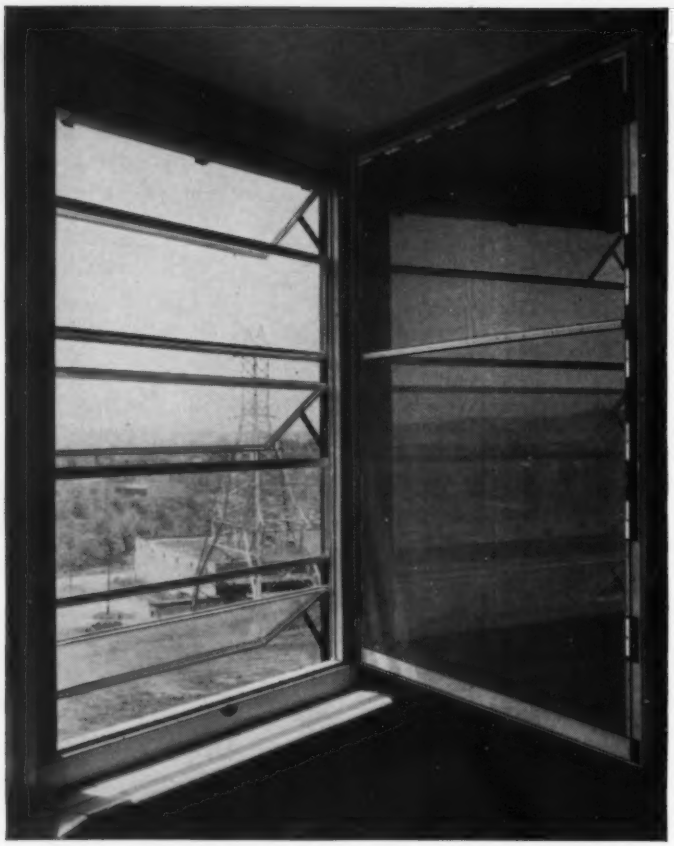
Throughout the day the recorded music is programmed to suit the needs of the various units at different times.

Optional Retirement System Offered Kentucky Employees

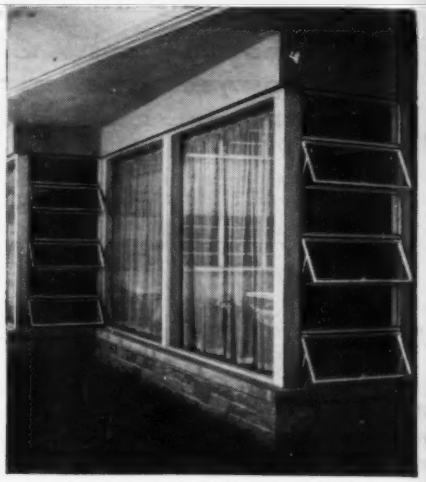
All employees of state institutions and agencies in Kentucky are eligible for participation in a State Employees' Retirement System, which went into effect this past July. Personnel who enrolled in the system as of July 1 were given credit for past State service. Those who do not wish to participate must sign a statement of non-membership by October 1.

The cost to employees—2½% of the monthly salary up to $350 and 4% of any amount above—is made by payroll deductions. Each participant will receive a yearly report of his contributions and accrued interest.

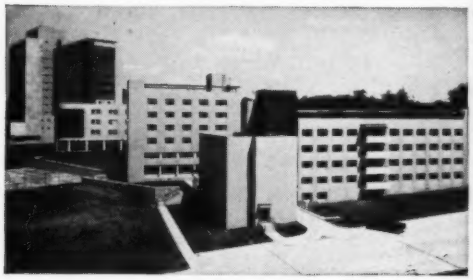
Retirement benefits are available to participants at age 55 who have served twenty years or to those who retire at 65 with ten years' service. Anyone who becomes permanently disabled after 15 years' service is eligible for retirement pay regardless of age. Any subscribing employee who leaves State service before he is eligible for retirement will receive the amount he contributed plus accumulated interest.



The detention screen, used with this Truscon Intermediate Louver Window, is the principal restriction against injury and escape. Screen can be opened only by authorized use of a removable key.



These Truscon Intermediate Louver Windows offer 50% ventilation, are particularly suited to the needs of mental hospitals. A similar design provides 100% ventilation. Ventilators operate simultaneously.



Eastern Pennsylvania Psychiatric Institute, Philadelphia, Penna.; Harbeson, Hough, Livingston & Larson and Harry Sternfeld, Architects.

TRUSCON DETENTION WINDOWS combine apartment-like beauty with complete protection and safety

It's hard to believe from the casual, inviting appearance of these handsome Truscon Intermediate Louver Windows that they provide detention. That's because they're designed to conceal or minimize any appearance of enforced restraint. At the same time they're carefully engineered to protect mental patients against self-injury and to prevent escape.

Like all Truscon Steel Detention and Psychiatric Windows, they make maximum use of large total glass and ventilating areas for abundant healing sunlight and fresh air. Yet, they provide all the necessary margins of safety.

The degree of restraint can be entirely controlled by authorized personnel who operate the windows by a small removable crank—open or close the detention screens (above left) with a removable key.

You can benefit from Truscon's extensive specialized experience in the design and construction of steel windows for safe confinement of mental patients. Simply ask your nearest Truscon® representative for technical assistance. Catalog includes complete specifications. Send coupon for free copy.

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Building Study Reveals Significant Trends

For a number of years, the public press has been publishing articles on overcrowding in mental hospitals, almost concurrently with accounts of bond issues and some millions of dollars of tax money being spent on new construction. At the same time that hospital people were begging their legislatures for money to improve existing buildings or to construct new ones, we were told that our most urgent need was for better personnel in order to improve programs. Many among us have living proof of the fact that a good program can be operated in an old and far from perfect building, or that, conversely, a new building does not necessarily mean a fine program. While a spandy new building is not essential in attaining the "therapeutic environment", the better the building, of course, the greater the potential of the treatment program.

In November 1955, both because of the many requests for accurate data and their own urgent need for an authoritative indication of current trends, the Architectural Study Project undertook to make a nationwide survey of appropriations for construction during the current period. The survey covered all 48 states, but excluded the Territories and the District of Columbia. Although the states had been asked to show appropriations requested, but not yet passed, it was decided to include in the tabulation only monies already in hand at the time the information was given.

Appropriations, as shown in the following tables, varied from state to state, with some states reporting no appropriations for construction during this particular budget period. Other states, including New York, Virginia and Connecticut, were appropriating considerable amounts for construction at that time.

New York, as might be expected, appropriated more than 25% of the total for the entire United States. However, New Mexico, with one of the smallest appropriations, actually had a higher per capita expenditure for capital improvement. Connecticut and Virginia were also high on this basis.

Of the country-wide total of seven hundred and fifty million dollars, actual patient housing accounted for more than 54%—not surprising considering the huge percentage of overcrowding reported by almost every state. Nor is it surprising that the addition, expansion or renovation of utilities and maintenance facilities accounted for 14% of the total. It may be hoped that the addition of so many service buildings, so much fire-proofing and the improvement of heat, light and power facilities will result in better physical operation of the institutions, and as a result, better living conditions for patients and employees.

An encouraging note is the almost 10% which went into General Medical and Surgical Buildings. Normally, only from one to five per cent of a mental hospital population are physically ill, but the G.M.&S. buildings are costly to erect. This fairly large percentage indicates the increasing concern of hospital people for the physical health of their population, and their recognition that physical health can contribute greatly to the improvement of the psychotic conditions.

Also on the positive side, the 11% of the total earmarked for Admission, Receiving and Treatment Buildings shows the increasing trend toward active, short-term treatment for the acutely mentally ill. The percentage is slightly higher for specific treatment buildings, which include continued treatment, tuberculosis and disturbed buildings pointing clearly to the problem of the "old chronic", as does the 7% allocated for geriatric buildings and infirmaries.

It is a pity that more urgent needs kept the percentage for activities and similar buildings as low as 1.7% of the total. Today, a good well developed activity program is considered one of the basic treatment modalities in mental hospitals. In defense of this figure, however, it may be pointed out that many of the other patient buildings contain some facilities for activities. Nonetheless, today's increasing emphasis on activities calls for greater emphasis on suitable facilities.

"Indirect care" facilities accounted for 12% of the total, and included administration buildings, housing for staff, laundries, educational and training facilities and food service facilities. The dietary service appropriation was the highest in the "indirect" category, and actually accounted for 4% of the overall appropriations for the period. This clearly indicates the growing awareness of medical staffs, legislatures and others that a good food service is basic to morale and the therapeutic environment.

According to Public Health Service figures, the years 1954 and 1955 were boom years for hospital construction, and the pattern over the years is irregular and somewhat unpredictable. The needs, however, are still great, and hopefully future tabulations will show greater appropriations for acute-treatment and activity facilities in proportion to patient-housing and repairs necessitated this time by overcrowding and obsolescent buildings.

This study was prepared by the Architectural Study Project and tabulated by Mr. Glenn R. Studebaker of the Project staff.

TOTAL AMOUNTS APPROPRIATED FOR NEW CONSTRUCTION, ADDITIONS AND RENOVATIONS TO MENTAL HOSPITAL FACILITIES, AS REPORTED BY STATE AUTHORITIES, AS OF NOVEMBER, 1955.

TABLE I.

Facilities for Direct Care and Treatment of Patients.

	(000)	Geriatric Care[2] (000)	Ward Bldgs.[2] (000)	Admission, Receiving & Treatment Bldgs.[2] (000)	Specific Treatment[2] Bldgs.[3] (000)	Multi-Purpose Bldgs.[2] (000)	Med. & Surg. Bldgs.[2] (000)	Infirmaries All Types[2] (000)	Activity Bldgs.[4] (000)[2]	Maximum Security[2] (000)	Major Additions[2] (000)	Special Purpose[2] Bldgs.[5] (000)
Total for Continental United States...	534,324[1]	25,618	118,099	81,317	82,582	46,510	72,790	27,979	7,669	8,855	58,225	4,680
Alabama	970	970										
Arizona	355	200			150					5		
Arkansas	None reported											
California	50,318	1,244	25,275	12,997		9,297			318	165	706	316
Colorado	None reported											
Connecticut	26,399		101	14,926	5,379		956		3,605	76		1,356
Delaware	2,200		525		350		925				400	
Florida	14,788	2,215	1,350		500						10,723*	
Georgia	1,250			1,200	50							
Idaho	None reported											
Illinois	13,109		2,015	8,000		60	2,656		280			98
Indiana	2,928		2,832					24				72
Iowa	4,000	2,000			2,000							
Kansas	6,190		1,020		4,600	470			20			80
Kentucky	1,500			1,500								
Louisiana	12,433		5,023	3,983	1,000						2,387	40
Maine	2,937	771			1,757					409		
Maryland	5,046	880	1,416				750			2,000		
Massachusetts	41,718		2,026	13,178	5,395		6,252	1,085			12,092	1,690
Michigan	28,462		11,128	400	3,800	5,862		250	2,000	590	3,812	620
Minnesota	9,384		3,464		1,500	4,350		70				
Mississippi	None reported											
Missouri	1,486		1,486									
Montana	1,750		250	1,500								
Nebraska	2,665				980		885			800		
Nevada	587	540		47								
New Hampshire	548			298					250			
New Jersey	12,327	2,112	6,068		2,048	310			342	53	1,259	135
New Mexico	2,247		919	574		660					94	
New York	145,640	1,000	7,000	8,540	38,700	7,200	56,900	26,300				
North Carolina	9,219		6,353					250	168	275	2,000	173
North Dakota	1,080			1,080								
Ohio	6,672		944	350			623			5	4,750	
Oklahoma	683		250			400			33			
Oregon	8,925	1,600	360			285					6,580	100
Pennsylvania	36,688	1,816	4,502	2	190	17,086				190	12,902	
Rhode Island	6,000	6,000										
South Carolina	8,612		6,016	2,066		530						
South Dakota	None reported											
Tennessee	6,600		2,000	4,000						600		
Texas	25,123	1,600	11,553	1,470	7,350		2,200		430		520	
Utah	None reported											
Vermont	None reported											
Virginia	16,864	2,070	7,243	1,360	3,833		173		23	2,162		
Washington	3,280		1,755							1,525		
West Virginia	5,825	600	5,225									
Wisconsin	6,471			3,471	3,000							
Wyoming	1,045			375			470		200			

[1] Does not include D. C. or Territories.
[2] Includes major repairs to existing buildings and new buildings for continued treatment and convalescent patients.
[3] Includes buildings specified as continuous treatment, tuberculosis and disturbed.
[4] Buildings specifically for occupational therapy, recreation and physical therapy.
[5] Auditoriums, chapels, assembly halls, gymnasiums.
* Includes new hospital constructed in Broward County.

TOTAL AMOUNTS APPROPRIATED FOR NEW CONSTRUCTION, ADDITIONS AND RENOVATIONS TO MENTAL HOSPITAL FACILITIES, AS REPORTED BY STATE AUTHORITIES, AS OF NOVEMBER, 1955.

TABLE II.

Facilities for Indirect Care and Treatment of Patients.

		Administrative Facilities New & Renov. (000)	Housing for Employees & Staff (000)	Dietary & Food Service (000)	Laundry Facilities New and Renov. (000)	Educational & Training Facilities (000)
Totals for Continental United States	84,666[1]	5,627	22,030	26,990	13,940	16,079
Alabama	None reported					
Arizona	43	13		30		
Arkansas	None reported					
California	10,398	189	1,000	6,079	3,130	
Colorado	None reported					
Connecticut	4,421		2,609	922	890	
Delaware	510		95	415		
Florida	626		266	295	65	
Georgia	None reported					
Idaho	None reported					
Illinois	5,368		2,152	1,761	1,219	236
Indiana	3,039	60	1,769	998	201	11
Iowa	None reported					
Kansas	1,634	35	860	537	202	
Kentucky	203		203			
Louisiana	473		93	380		
Maine	614		375	10	129	100
Maryland	1,945		200	545		1,200
Massachusetts	1,243		360	883		
Michigan	9,368	1,650	643	4,615	1,560	900
Minnesota	1,925	1,675	150	100		
Mississippi	None reported					
Missouri	None reported					
Montana	200		200			
Nebraska	None reported					
Nevada	None reported					
New Hampshire	112			80	32	
New Jersey	208			200	8	
New Mexico	295		40	110	145	
New York	11,385	320	1,300	1,900	4,465	3,400
North Carolina	13,877	15	4,421	441		9,000
North Dakota	322		300	22		
Ohio	1,509		603	35	239	632
Oklahoma	586		16	500	70	
Oregon	761	194	167	400		
Pennsylvania	2,147		273	714	1,160	
Rhode Island	None reported					
South Carolina	1,451		153	1,298		
South Dakota	365		365			
Tennessee	615		465			150
Texas	1,150	450	350	250	100	
Utah	None reported					
Vermont	None reported					
Virginia	3,752	1,026	1,951		325	450
Washington	4,102		641	3,461		
West Virginia	10		10			
Wisconsin	None reported					
Wyoming	9			9		

[1] Does not include D. C. or Territories

TOTAL AMOUNTS APPROPRIATED FOR NEW CONSTRUCTION, ADDITIONS AND RENOVATIONS TO MENTAL HOSPITAL FACILITIES, AS REPORTED BY STATE AUTHORITIES, AS OF NOVEMBER, 1955.

TABLE III.

Utilities and Mechanical Services: Additional, Expansion and/or Renovation

	(000)	Heat, Light and Power (000)	Water Supply (000)	Sanitary Facilities[2] (000)	Refrigeration and Air Conditioning (000)	Fireproofing and Protection (000)	Roofing, Repairs & Renovation (000)	General Repairs and Improvements (000)	Improvements of Grounds & Bldg. Sites (000)	Transportation and Communication (000)	Service Buildings & Shops[3] (000)	Farm Bldgs. and Facilities (000)
Total for Continental United States	105,430[1]	47,851	4,198	6,359	490	10,964	638	13,073	3,101	371	16,834	1,551
Alabama	None reported											
Arizona	73	66									7	
Arkansas	None reported											
California	3,555	239	481	541			61	561	1,379		293	
Colorado	765	765										
Connecticut	6,661	3,944	601	263		247		819	181	13	50	543
Delaware	None reported											
Florida	1,958	1,448	400							110		
Georgia	None reported											
Idaho	None reported											
Illinois	6,303	4,462		897	14		195		632			103
Indiana	5,385	3,750	199	669	61	63	145	315	11		102	70
Iowa	None reported											
Kansas	2,081	1,555	178	68	10	110		75	70	15		
Kentucky	None reported											
Louisiana	1,090	42	80	600				350			18	
Maine	922	125			100	140		181		64		312
Maryland	565										565	
Massachusetts	11,191	3,204	501	997	179	3,053	125	2,419		126	587	
Michigan	1,410	1,000									410	
Minnesota	1,970	995									975	
Mississippi	None reported											
Missouri	None reported											
Montana	50										50	
Nebraska	None reported											
Nevada	None reported											
New Hampshire	233	63				82	16	30				42
New Jersey	2,448	569		74		1,805						
New Mexico	388	250							138			
New York	26,331	13,630				143					12,558	
North Carolina	575			145				78	195		50	107
North Dakota	250		250									
Ohio	1,393	410	23	301	11	98	96	111	48		278	17
Oklahoma	310	80	65	165								
Oregon	33											33
Pennsylvania	17,138	8,125	1,030	681	97			7,001			135	69
Rhode Island	None reported											
South Carolina	653	322						320			11	
South Dakota	None reported											
Tennessee	1,205		200	300		400		100			205	
Texas	None reported											
Utah	None reported											
Vermont	None reported											
Virginia	7,437	1,444	190	658	18	3,729		433	447	43	475	
Washington	1,000	400						280			65	255
West Virginia	950					950						
Wisconsin	1,107	963				144						
Wyoming	None reported											

[1] Does not include D. C. or Territories
[2] Plumbing, sewerage and garbage disposal
[3] Garages, maintenance shops, stores & warehouses, etc.